CIVIL DISTRICT COURT
PARISH OF ORLEANS
STATE OF LOUISIANA

GLORIA SCOTT AND	*	
DEANIA JACKSON	*	
	*	NO. 96-8461
VERSUS	*	DIVISION "I"
	*	SECTION 14
THE AMERICAN TOBACCO	*	
COMPANY, INC., ET AL.	*	
	*	

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Transcript of proceedings before The Honorable Richard J. Ganucheau, Judge Pro Tempore, Civil District Court, Parish of Orleans, State of Louisiana, 421 Loyola Avenue, New Orleans, Louisiana 70112, commencing on June 18, 2001.

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Thursday Afternoon Session
March 20, 2003
1:35 p.m.

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I N D E X

P R O C E E D I N G S

THE BAILIFF:
All rise for the jury, please.
(Whereupon the jury joins the proceedings at this time.)
THE LAW CLERK:
Recess is over. Court will come to order.
THE COURT:
Please be seated.
Mr. Gay, are you ready to continue?
MR. GAY:
Yes. Thank you, Your Honor.
Good afternoon, everyone.

THE JURY:
Good afternoon.
CROSS-EXAMINATION
BY MR. GAY:
Q. Dr. Sartor, you are familiar with -- God bless you.
A JUROR:
Oh, thank everybody.
EXAMINATION BY MR. GAY:
Q. Dr. Sartor, you are familiar with the NCI PDQ® on screening for bladder cancer?
A. I'm familiar with the PDQ®. I'm not sure I could quote all the PDQ® data but, yes, I'm familiar with PDQ®.
Q. And, specifically, the NCI PDQ® on screening for bladder cancer?
A. I mean, I'm sorry, I just -- I'd really have to look at it before I would be comfortable in

saying I'm familiar with it.
Q. Okay. Well, the PDQ®, as you've described yesterday, is a Physicians Desk Query; right?
A. That is correct.
Q. That's for physicians who want to know something about a given topic in medicine, can pull it up, and get the NCI's latest views on it; right?
A. That is correct.
Q. And the purpose of the National Cancer Institute doing that is to assist physicians in their treatment of patients; right?
A. Yes.
MR. GAY:
Okay. Can we pull up, Ted, LR-1829?
EXAMINATION BY MR. GAY:
Q. Do you have it in front of you, Doctor, on the screen?
A. On the screen.
Q. Do you need a hard copy?
A. If you did have it, it would be appreciated. Thank you very much.
Q. You're welcome.
Now, Mr. Belasic showed you something similar yesterday concerning lung cancer screening; right?
A. That is correct.
Q. And this is the NCI's statements to physicians on screening for bladder cancer; right?
A. Yes.
MR. GAY:
May we publish, Your Honor?
THE COURT:
Is it in evidence?

MR. GAY:
No, it's not in evidence, I don't believe.
MS. DeSUE:
No.
THE COURT:
Any objection?

MR. LEGER:
No objection, Your Honor.
THE COURT:
You may publish.
MR. GAY:
And move to admit, Your Honor.
All right. Now, Ted, could you highlight the first three lines under "Health Professional Version, Date Last Modified" and "Screening for Bladder Cancer"?
Can you blow that up, Ted?
All right. Move that up on the screen.

EXAMINATION BY MR. GAY:

Q. Now, do you see there, Doctor, that this was last modified February 11th, 2003?

A. Yes, I do.

Q. And it's the NCI's statement on screening for bladder cancer; correct?

A. That is published in PDQ®.

MR. GAY:
Ted, could you also blow up the "Summary of Evidence" paragraph down at the bottom.
Do you see that?

EXAMINATION BY MR. GAY:

Q. Okay. Now, Doctor, the "Summary of Evidence"

by the NCI indicates "There is insufficient evidence to determine whether a decrease in mortality...."
Now, that means whether its saves lives; right?

A. Well, that's one measure.

Q. "...whether a decrease in mortality from bladder cancer occurs with hematuria testing...."
That's your urine test; right?

A. That is correct.

Q. "...and with urinary cytology testing...."
That's another test you suggested?

A. That is correct.

Q. "...or a variety of other tests on exfoliated urinary cells or other urinary substances"; right?

A. That's what it says.

Q. Now, that "exfoliated urinary cells or other urinary substances," that's the NMP-22 test you're talking about, amongst others?

A. Yes, the NMP-22 would be under the "other urinary substances."

Q. Then it says, "The only screening test that has been evaluated in the general population (men over 50) is hematuria testing"; right?

A. That is correct.

Q. Then it says, "The potential harm is a high frequency of false positives...."
Right?

A. That's what it says.

Q. That's what we were talking about earlier this morning, that this test can lead you down the wrong road from time to time; right?

A. It has that potential.

Q. "...which may lead to unnecessary cystoscopy...."
We discussed that; correct?
A. Yes, we did.
Q. "...or other invasive procedures"; right?
A. Yes, that is correct.
Q. And, again, the NCI here is idealizing the risk of harm versus the risk of benefit from the screening test; right?
A. That was theirs. Although it's interesting that the FDA made a different conclusion on the "other urinary substances." And it was also interesting that one of the things I tried to do in recommendations was not to go straight to cystoscopy.
MR. GAY:
You can take that down, Ted.
EXAMINATION BY MR. GAY:
Q. Doctor, are you familiar with the Ochsner Health Plan guidelines for preventive procedures?
A. No, I'm not.
Q. You haven't read those?
A. No, I have not.
Q. It wouldn't surprise you if your screening tests are not on there; would it?
A. Is that the HMO? The Ochsner Health Plan HMO?
Q. OHP is the Ochsner HMO.
A. Yes, it would not surprise me at all.
MR. GAY:
Okay. Now, Ted, please pull up AN-000593.

Your Honor, it's been admitted. It was used this morning. May we publish?
THE COURT:
Do you agree that it's in evidence?
MS. DeSUE:
Yes, Your Honor.
MR. LEGER:
Yes, Your Honor.
THE COURT:
Okay. You may publish it.
MR. GAY:
And, Ted, could you please publish the foreword of this book?
EXAMINATION BY MR. GAY:
Q. We're back again talking about this book; right, Doctor? Published by the United States -- It's a report by the United States Preventive Services Task Force; right?
A. But may I ask the date? Because I'm not familiar. There were different versions of that book.
Q. This is the Second Edition. And I believe it's in the mid nineties. You're welcome to look at it.
A. Thank you.
I mean, I just wanted to check the date because there are various versions.
Q. Yes. I think that's the latest version.

A. That's the 1996 version.
MR. GAY:
Now, could you, Ted, blow up the last sentence of the first paragraph of the

foreword? And blow that up for the jury.
EXAMINATION BY MR. GAY:
Q. This is, Doctor, a statement by Philip R. Lee, who was a doctor and he was the Assistant Secretary for the United States Department of Health and Human Services; correct?
A. That is correct.
Q. And he states here "The First Edition of The Guide is widely regarded as the premier reference source on the effectiveness of clinical preventive services -- screening tests for early detection of disease, immunizations to prevent infections, and counseling for reduction of risk."
Do you see that?
A. That is what he says.
Q. And there's a book that I've handed you, Doctor, that are the recommendations of this task force. And you indicated it's made up of a lot of private scientists and doctors and government scientists and doctors; right?
A. Well, and I'm not intimately familiar with all of their procedures. My understanding is that they put together panels, and then give very strict guidelines, and then ask that the panel come to some conclusions, which are then published after review.
Q. Right.
A. That's my understanding.
Q. Okay. Fine.
MR. GAY:
Now, if we could go to -- I never know how to describe these pages. It's xlii, Ted, under "Methodology." Could we bring that up

and publish it?
THE COURT:
Do you wish to publish it?
MR. GAY:
Yes, Your Honor.
THE COURT:
You may publish it.
EXAMINATION BY MR. GAY:
Q. Now, this page is the "Introduction" in the "Methodology" chapter; right, Doctor?
A. Yes.
I'm trying to figure out exactly where we are. I've got the "Methodology." What -- I can't read the screen. What page is it up there again, please?
Q. I guess it's little Roman numeral xlii.
A. xlii.
Okay. I'm just trying to get to the same page because it's hard for me to read up there unless you blow it up.
Q. Well, let's blow up the methodology and the

page number for Dr. Sartor.
A. Okay.
Q. Do you see that, Doctor?
A. Yes. I'm here. Thank you. I'm on the same page as you are.
Q. No problem.
Okay. Would you blow up the two bullet point paragraphs on that page?
Now, Doctor, would you agree with me that in "Methodology," they're talking about what is the method they have used to determine whether a

screening test is appropriate or not?
A. Yes.
I was reading above there. And then what they say is the screening test must satisfy two major requirements to be considered effective.
Q. Okay. And so one of the requirements is "The test must be able to detect the target condition earlier than without screening."
Do you see that?
A. Yes. And I agree with that.
Q. "And with sufficient accuracy to avoid producing large numbers of false-positives and false-negative results (accuracy of screening test)."
You agree with that; don't you?
A. You know, not exactly.
And, you know, this is what we discussed earlier about the difference between accuracy and being able to segregate people into various risk stratifications. So, I mean, what I think they're looking at is a, you know, kind of a single test and then going on. So the accuracy is only one of several elements that needs to be evaluated.
Q. Then the next criteria they indicate is "Screening for and treating persons with early disease should improve the likelihood of favorable health outcomes"; correct?
A. Yes.
Q. So, in other words, if you screen them and you find something, you ought to be able to improve the outcome; right?
A. Yes. Absolutely.

Q. And typically with screening tests, that is whether it reduces mortality; right?
A. Well, that's one of the criteria. You know, there are various criteria that one can look at, but that is one.
Q. Yes.
And then you have to compare that to the treatment of patients when they present with signs and symptoms of the disease; right?
A. Yes. We certainly agree with that.
Q. To know whether you're making a difference?
A. Yeah. I mean, that's very important. I mean, as I mentioned a little bit earlier, you know, the screening never changes the survival of a

patient. It's only the screening which allows an early intervention to occur which is effective.
Q. If you're going to screen people for a given disease, let's say bladder cancer, you want to know whether you're doing some good; right? Making a difference?
A. We want to do -- And there are various ways to look at that. It doesn't necessarily have to be mortality. You can use a stage shift. And that, you know, there are four different criteria that you can evaluate screening tests. And one of them is mortality, but that's not the only one.
MR. GAY:
All right. Now, Ted, if we could go to Page 181 of The Guide.
May we publish, Your Honor?
THE COURT:
You may publish it.

EXAMINATION BY MR. GAY:
Q. Doctor, are you there?
A. Yes, I am.
Q. All right. This is the chapter, is it not, for screening for bladder cancer in the book we've been talking about?
A. Right.
And we've looked at a portion of the first paragraph a little bit earlier today.
Q. Right.
I was going to go up to the recommendation, up to the top, and ask Ted to blow it up and highlight it, along with "Screening for Bladder Cancer." Would you just blow that whole first section up?
"Screening for Bladder Cancer." And the recommendation is "Routine screening for bladder cancer with urine dipstick...."
That's another way of doing this microscopic hematuria?
A. Right. That is correct.
Q. Then it says "...microscopic hematuria -- excuse me, microscopic urinalysis, or urine cytology...."
Right? And that's another one of your tests?
A. Yes, that is correct.
Q. "...is not recommended in asymptomatic persons."
A. That is what it says.
Q. And then it says, "All patients who smoke tobacco should be routinely counseled to quit smoking"; right?

A. I certainly agree with that.
Q. And that's what's called primary prevention; right?
A. That's one of the terms it can go under.
Q. And the term for the type of screening you're talking about is secondary prevention? That's often described that way; is it not?

A. It might be described in that way. You know, there are different -- You know, when he's talking about primary and secondary, some people -- there are certainly some people who do that, absolutely.
Q. All right. And the best way to reduce your risk for bladder cancer is to quit smoking; right?
A. I think that if you want to prevent as opposed to early detect -- And this is, you know, you talked about primary and secondary. I generally use the terms "prevention" versus "early detection." If you want to prevent bladder cancer, the best thing you could do is stop smoking cigarettes.
MR. GAY:
All right. Now, can we go to Page 184, Ted?
May we publish, Your Honor?
THE COURT:
You may.
MR. GAY:
And blow up the first paragraph entitled "Recommendations of Other Groups."
EXAMINATION BY MR. GAY:
Q. Doctor, you see here it says, "No major organization recommends screening for bladder cancer in asymptomatic adults"?

A. Yes, I see that.
Q. That means people without symptoms?
A. Yes, it does.
Q. In other words, that means they don't recommend giving tests to people who are apparently healthy and trying to find out if something's wrong; right?
A. That is their recommendation.
Q. "The Canadian Task Force on the Periodic Health Examination recommends against routine screening" as well; does it not?
A. Yes, it does.
Q. And it, again, concludes that there's insufficient evidence for or against screening in specific high-risk groups?
A. Yes, that's what it says.
Q. And high-risk groups would be people who are environmentally exposed to things that cause cancer; right?
A. That is correct.
Q. That would include smoking?
A. Yes, it does.
Q. It would include people who work in the dye industry?
A. It certainly could.
Q. In the leather industry?
A. It could.
Q. It could include people who are just environmentally exposed to carcinogens; right?
A. Well, you know, with the bladder, we have a long history. And it would have to be specific. And when you say carcinogens, we know that some

affect the bladder; whereas, some others do not.
Q. And it says, "The American Cancer Society has not issued any specific guidelines on screening for bladder cancer"; right?
A. Well, you know, we've looked at material a little bit earlier from the American Cancer Society. And it is very conceivable, since this book is written in 1996, that they may not be up-to-date.
Q. Okay. Well, we'll get to that.
All right. Ted, could you also highlight on that page the "Discussion"? Just highlight the whole paragraph under "Discussion." And blow it up, please.
Okay. Now, Doctor, "Dipstick and microscopic urinalysis...."
That's your urine test; right?
A. That is correct.
Q. "...are simple and sensitive tests for detecting hematuria from early tumors"; right?
A. Yes.
Q. You agree with that?
A. I agree with that.
Q. "But they are not sufficiently specific to be practical for screening for bladder cancer in the general population"; right?
A. Yes, I agree with that, too.
But let me, you know, point out carefully that general population screening is not what has been recommended in my report.
Q. We're going to get to that.
A. Okay.
Q. The very next sentence, right, "Even among

older high-risk populations...."
That's your group; right?
A. Well, you know, I don't know if they're calling high risk because of age -- and we talked about how age is a risk factor -- or whether or not they're talking about age and smoking together as comprising the high-risk population.
So I'm not, I'm certainly not trying to quibble. But, you know, they're saying among older high-risk populations, which is the population that I've attempted to say that is at a high risk, that they are saying that it is "Even among older high-risk populations, the predictive value...."
And you don't mind if I read that?
Q. Not at all. I was going to read it to you as soon as you finish your explanation.
A. Okay. I was going to read it to you and then explain. However you'd like to go would be fine with me.
Q. Well, since you brought it up, Doctor, before we get to that, bladder cancer is diagnosed typically in older people; right?
A. Yes, that is correct.
Q. It's diagnosed typically in older white males; correct?
A. Well, you know, there is a little bit of typicality there. But I hate to get yourself segregated in too much.

Q. I don't know what you mean by that, Doctor.
A. Well, if you remember the slide that I showed a little bit earlier from the American Cancer Society, in men bladder cancer was the fourth most

common cause of cancer, and in women bladder cancer was about the ninth most common cause of cancer. So certainly -- Or maybe it was tenth. It might have been tenth.
Q. So with women the risk goes way down?
A. I wouldn't necessarily say it goes way down. It's the tenth most common cancer in America. I don't think that's way down.
Q. Okay.
A. You know, something -- something like there's a rare small cell of the bladder. Now, that's rare. That's something we don't have to screen for.
Q. But it says here, "Even among older high-risk populations...."
That's the population you're talking about, high risk; right?
A. Yes. Yes, we agree with that.
Q. "...the predictive value of a positive screening test is low."
A. I agree with that. We are in agreement.
Q. Okay. "As a result, many persons without cancer will require diagnostic workups for false-positive test results and will be subjected to the costs, discomforts, and risks of cystoscopy and intravenous pyelography."
That's what the task force believes will happen?
A. Yes, that is correct.
And just so -- I mean, I think it will be obvious to the jury and others that are present -- I did not recommend that those individuals with the positive predictive test, and that's going to be the

hematuria, I'm trying to use their words, the dipstick and microscopic urinalysis, which are simple, there's something else that I recommended before the cystoscopy in an effort to avoid just this problem.
Q. We talked about that this morning; didn't we?
A. We did. The NMP-22 and the cytology.
Q. And no matter what those say, they can't tell you whether you have bladder cancer or not?
A. We were very clear about the imperfection of all medical testing.
Q. Thank you.
Now, Doctor, it goes on to say, "More important...."
A. Yes. "More important...."
Q. "...there is no proof that early detection significantly improves the prognosis for the small minority of patients found to have a urological malignancy -- found to have urological malignancies."
A. Malignancies, yes, plural. And, yes, that's

what it says.
Q. So that is the opinion of this task force made up of the people you described; correct?
A. That is correct.
Q. And if you go a little bit further down, Doctor, sort of about the seventh line from the bottom, it says, "In the absence of such evidence, routine screening cannot be recommended, due to the high rate of false-positive results, and the possibility of harm to asymptomatic patients, few of whom have cancer."

Do you see that?
A. Yes, that's exactly what it says.
MR. GAY:
All right. Ted, can you blow up the sentence under "Clinical Intervention" on that same page? The first sentence of that paragraph.
EXAMINATION BY MR. GAY:
Q. Doctor, you see where they give it a D recommendation?
A. Yes. That means that they're not very certain of it.
Q. That means they don't recommend it; right?
A. No. No, their Level A recommendations are firm recommendations. Level F is no recommendation at all. Level D is the lowest level of recommendation that they can make.
Q. We just went over what they said, Doctor. Doesn't the D recommendation mean there's no proven benefit and there are known risks of complications of adverse effects from the test?
A. I -- We read over it in some detail and we reached agreement on some but not all points.
Q. All right. Now, Doctor, this book that you rely upon, DeVita --
A. It's a good book. I have a copy in my office.
Q. A good book. Chapter 25.
A. Okay.
Q. Chapter 25 is a whole section on bladder cancer; right?
A. Yes. It has a whole chapter on bladder

cancer.
Q. And it has a whole chapter on cancer screening; doesn't it?
A. Yes, it does.
Q. Can you show me in here where they recommend screening for bladder cancer?
A. No, I cannot show you where it is. I'm not really, you know, familiar, even though I have the textbook in my office, I can't quote all of it to you. It's a thick book, it's a good book, I use it as a reference source.
Q. Do you know whether they make a recommendation for screening for bladder cancer?
A. I am uncertain. I suspect -- Well, no, I

won't go there because the truth is I'm uncertain. I would -- I would have to look at the book in order to be certain.
Q. Now, you mentioned when we were talking about The Guide, Doctor, the American Cancer Society position on bladder cancer screening; right?
A. We looked at some of the American Cancer Society issues a little bit earlier.
MR. GAY:
Ted, can you pull up LR-2198?
EXAMINATION BY MR. GAY:
Q. This is the "American Cancer Society Guidelines for the Early Detection of Cancer," Dr. Sartor?
A. Yes. I'm looking at it on the screen here.
Q. Do you need a hard copy?
A. Yes. The Judge has been kind enough to give me a copy. It makes it much easier for me to read,

thank you.
MR. GAY:
May we publish, Your Honor? It's been admitted.
THE COURT:
Agreed?
MS. DeSUE:
Yes, Your Honor.
MR. LEGER:
Yes, Your Honor.
THE COURT:
You may publish it.
EXAMINATION BY MR. GAY:
Q. Now, Doctor, this is the "American Cancer Society Guidelines for the Early Detection of Cancer, 2003"; correct?
A. Yes. This is dated January 20th, 2003.
Q. Okay. Fairly recent; correct?
A. Yes, that is correct.
Q. There's a fellow by the name of Robert Smith, he's one of the major spokesmen for the American Cancer Society; isn't he?
A. Yes, he is Director of the Cancer Screening, Cancer Control Sciences Department.
Q. I've seen him on television from time to time about cancer issues. Have you?
A. No, I'm not a big watcher of television.
Q. Now, Doctor, you talked about the American Cancer Society's recommendations for bladder cancer screening awhile ago. Would you look through there -- Well, first, before we do that, these are their guidelines that they publish for doctors to follow

about cancer screening; right?
A. I'm not sure. You know, it's interesting, I've seen other guidelines. This appears to be one. Now, I'm interested in seeing that this was what was published in January 2003. But I've also seen other materials quite recently that seem to be distinct from this particular one.

I mean, let's find an area of agreement. I always think that's important. You know, the article is by Robert Smith, it is the American Cancer Society guidelines. I'm not sure if there are other guidelines that may not be within the context of this article.

Q. Well, this is an American Cancer Society publication about the early detection of cancer, 2003. Can we agree on that?

A. Absolutely, we do agree.

Q. And these are guidelines that the American Cancer Society publishes; correct?

A. Well, I mean, it's sort of interesting. There is a distinction --

Q. Doctor, would you just answer my question? It may be interesting, but can you just answer that question?

THE COURT:

Doctor, under the rules you should answer with a "Yes" or "No," if you're able to; then if you'd like to explain your answer after that, you may do so.

THE WITNESS:

May I have the question repeated, please?

THE COURT:

The question was: "And these are guidelines that the American Cancer Society publishes; correct?"

THE WITNESS:

No.

EXAMINATION BY MR. GAY:

Q. These are not published by the American Cancer Society?

A. I am uncertain. It's published by Robert Smith. I'm sorry. I'm sorry. You know, this is a journal article. I am unsure of whether or not this represents the guidelines of the American Cancer Society in their total or whether it represents a subset or whether it might represent the views of Mr. Robert Smith who works for them.

So it is, you know, it's a little bit puzzling to me. It's sort of interesting. I have seen this one but I've not looked at it closely, so I'm not completely sure what it represents.

Q. Okay, Doctor.

A. There may be --

MR. GAY:

Pull up the paragraph under "ABSTRACT" and blow it up, Ted.

EXAMINATION BY MR. GAY:

Q. Doctor, would you agree with me that this says the American Cancer Society "Each January publishes a summary of existing recommendations for early cancer detection, including updates, and/or emerging issues that are relevant to screening for cancer"?

A. Yes.
Q. And do you agree with me that that's what this is?
A. I'm not absolutely positive that's what this is. And I hope that I don't appear too, you know, uncertain. I just haven't looked at this one in detail and I'm uncertain if it represents all of their guidelines or not. That's the only point that I would like to make.
Q. Okay. Well, that's fine, Doctor.
Look through there and show me where they recommend screening for bladder cancer.
A. I've very quickly looked through it and I see no section; whereas, I know that in other versions that I have examined that there are sections on bladder cancer, which is why I raise the issue or question whether or not this represents their total recommendations.
Q. Now, Doctor, you do not know of any study -- you can take that down, Ted -- you do not know of any study that has shown that screening smokers and former smokers with hematuria testing, urine cytology and NMP-22 will save lives; correct?
A. That is correct.
Q. And your proposal here to this Court has never been tested or evaluated in any way; has it?
A. Well, the components have been tested in detail. And the entire program put together was not.
Q. And no public health or major medical organization has ever said that screening all smokers and former smokers for bladder cancer is

medically necessary; correct?
A. I'm -- I'm unsure. I'm unsure of my answer to that.
Q. Well, let me see if I can help you, Doctor.
A. All right. Maybe if you repeated it, I might be in a little better position.
Sure. I mean, whatever you'd like.
Q. I'm sorry, Doctor. What? You said you're unsure. I told you I was going to help you out with something.
A. Thank you.
Q. Because you did give a deposition about this. You recall that; right?
A. I do recall parts of my deposition, not all.
THE COURT:
Doctor, would you like that question read back to you?
THE WITNESS:
If it were, it might be helpful to me.
MR. GAY:
That's fine.
THE COURT:
Here is the question: "And no public health or major medical organization has ever said that screening all smokers and former smokers for bladder cancer is medically necessary; correct?"
THE WITNESS:

I agree with that statement because none has ever said that you should screen all smokers and former smokers and that it is medically necessary. No one has ever made

that statement, to my knowledge.

Now, that is different than what has been said elsewhere in terms of guidelines that have been issued about high-risk individuals in the early detection of bladder cancer.

EXAMINATION BY MR. GAY:

Q. Okay. Thank you, Doctor.

Just, hopefully, a few more questions, Doctor.

When does someone get these tests you have suggested to The Court?

A. "These tests" are pretty broad. I wonder if you might specify which ones.

Q. Well, there's only three of them that you suggested. Those are the ones that I'm referring to. When do they get them? What's the criteria for getting them?

A. For the urinalysis and --

Q. Yes.

A. Okay. Well, there are different criteria for individuals who might have complaints of symptoms. It's very appropriate to examine the urine for those individuals who are at high risk, I think it is appropriate to examine them for certain factors. And then, of course, for individuals who might have, say, a kidney disease or maybe diabetes, that you might want to examine these tests. There are a variety of indications.

MR. LEGER:

Your Honor, --

EXAMINATION BY MR. GAY:

Q. But, Doctor, we're not talking about people who have symptoms in this case; are we?

A. No, we're not. I mean, you asked when these tests might be utilized. And I --

Q. Fair enough.

A. Okay.

Q. Let me --

MR. LEGER:

May we approach, Your Honor?

THE COURT:

Yes.

(Whereupon a bench conference is held at this time as follows:)

MR. LEGER:

Your Honor, my apologies for interrupting. I just have a fear that he's about to get into program details. And I didn't want to interrupt the question, but I just wanted to get, you know, because there's criteria and there's -- You know, when he asked when, that's all. And I want to object

to any questions regarding programs and plan and that kind of thing.

MR. BELASIC:

Your Honor, it's not only not a program; it's the exact question that Mr. Herman asked Mr. Burns. He asked him when were they going to get it. Dr. Burns gave him an age, age 50.

THE COURT:

I don't know that it's appropriate for you to argue something when Mr. Gay is

crossing, but you're doing it.

MR. GAY:

I would say the same thing, Judge.

THE COURT:

You would say the same thing. Okay. Mr. Long?

MR. LONG:

I may also add that on this witness, Mr. Leger, over my objection, asked him questions about all the Louisiana and other doctors who got together to make the recommendations and proposals. I objected. That went on.

And he asked did Dr. Emory agree to these recommendations and proposals? Did this doctor agree to the recommendations and proposals?

They've opened the door, we're entitled to ask these doctors about these recommendations and proposals.

MR. LEGER:

Judge, I didn't ask about the details of the proposals. In the proposals were recommendations.

THE COURT:

I'll let you go a little bit into it but let's try to keep it succinct, please.

MR. LEGER:

Thank you.

(Whereupon the bench conference is concluded at this time.)

EXAMINATION BY MR. GAY:

Q. Doctor, do you remember the question?

A. I'd like you to repeat it. I'm not sure I remember it.

Q. Under what circumstances do people get who have no -- These screening tests you've talked about, when do you get them?

A. When would it be appropriate to get them?

Q. Yes.

A. If they're at high risk for diseases that could be detected early and which, when treated, would be able to improve the quality of life of the patient.

Q. Well, for example, Doctor, we talked earlier today about a smoker who only smoked a minimal amount of cigarettes. When do those people become

eligible for bladder cancer screening?
A. You know, that's an interesting question. And one that would require very careful thought.
Q. Because?
A. Well, the risk increases with cigarette exposure and the risk increases with age.
Q. So you have to know the circumstances of the patient before you can recommend these things?
A. Well, you need to know their age and smoking history. I think we agreed on that.
Q. Okay. And so someone in the class who has a minimal smoking history and reaches some age, what age would that be?
A. Well, it's interesting that -- There are different criteria. And it was my understanding that that would be decided at a later date. So I have a little hesitancy to say at exactly which age. I know the age that I put in my initial report which

was composed back in 2000.
Q. All right.
A. And that age --
Q. So it depends on age; right?
A. Yes, it does depend on age.
Q. It depends on smoking history?
A. Yes, it does.
Q. You need to know the details about the smoking history; right?
A. Well, the two relevant details are the intensity and duration of smoking, something we call pack/years.
Q. So in order to recommend these things, you've got to look at an individual person and exercise your judgment as to whether that person meets the high risk requirement you talked about; right?
A. No. I said you need to know the age and the pack/years of smoking.
Q. Well, if you individually examined, let's say, a hundred members of this class, all right, present and former smokers, you might find that a bladder cancer test was reasonably necessary for some but not reasonably necessary for others; right?
A. Yes, that's correct. Because you could have smokers that were 13 years old.
Q. Well, you could have a smoker who in 1995 started smoking and he wouldn't be eligible till much later based on his age if he -- Let's say he started smoking at the age of 18 in 1995. He's not going to be eligible for bladder cancer screening till -- for a long time; right?
A. Until some later point, yes. And my understanding is that that would be determined at a later date.

Q. And you would have to wait for that person to find out what in the world his smoking history was ten, twenty-five years later; right?
A. Well, you would not be able to accurately determine a smoking history twenty to twenty-five

years later without asking him; however, you would know that he was of a certain age and that he had a certain smoking history.
Q. So you don't know whether that particular individual, when he reaches the age where he'd be eligible for this test, it would even be medically necessary for him; do you?
A. You know, I can only base what I know on today's data. It's very difficult for me to project into the future and say what I might know then. What I would feel highly confident of is that at the time that I were to evaluate the data that I would make the best recommendations that I knew how to.
Q. Well, you would agree with me that someone who started smoking in 1995 at the age of 18, smoked for one year or even two years and quit, would not be at a significantly increased risk for bladder cancer twenty-five, thirty years later?
A. No, I would not necessarily agree to that.
And one of the issues that I covered earlier, I think it was in the DeVita textbook or the NCI reference, was making note of the fact that if you quit smoking, that there is a decrease in risk; however, at that time I pointed out that the kinetics of that decreased risk are something that

I had some difficulty with defining very precisely. And so it's an area that I'd like to be having data instead of simply some recommendations.
Q. Do you know, Doctor, whether Gloria Scott has been prescribed bladder cancer screening?
A. I do not know that. I've never looked at her medical records.
Q. You don't know whether she's been prescribed it?
A. No, I do not know that.
Q. You don't know whether Deania Jackson has been prescribed it?
A. No, I do not know that.
Q. You don't know whether anybody except yourself has been prescribed bladder cancer screening in this class; do you?
A. No, I disagree with that. And, you know, I had done personally some bladder cancer screening before in the industrial setting. And it was also interesting, I took smoking histories, how many of those individuals also smoked.
Q. Now, Doctor, who do you envision to give these tests?
A. I'm sorry?
Q. Who do you envision will give these tests?
A. Would actually give the tests?
Q. Yes, sir.
THE COURT:
Mr. Gay, approach the bench.
(Whereupon a bench conference is held at this time as follows:)
THE COURT:

Who gives the test and under what circumstances is something I decide after Phase II. I'm going to instruct him not to answer that question. Go on to something that's relevant to liability and fault and causation.

(Whereupon the bench conference is concluded at this time.)

THE COURT:

Don't answer that question, Doctor.

The next question, please, Mr. Gay.

EXAMINATION BY MR. GAY:

Q. Doctor, were you given access to the medical records of Ms. Jackson and Ms. Scott?

A. I don't recall that I was.

Q. Okay. You have no reason to believe that anyone has recommended bladder cancer screening for either one of them then; right?

A. I'm sorry, I'm unaware.

MR. GAY:

Thank you, Doctor. That's all the questions I have.

THE WITNESS:

Thank you very much.

THE COURT:

Any other cross-examination of this witness?

MR. SCHNEIDER:

Yes, Your Honor.

Your Honor, may I approach the witness and get from him The Guide to Clinical Preventive Services?

THE COURT:

Yes.

MR. SCHNEIDER:

Good afternoon, Dr. Sartor.

THE WITNESS:

Good afternoon.

MR. SCHNEIDER:

Good afternoon, ladies and gentlemen.

THE JURY:

Good afternoon.

CROSS-EXAMINATION

BY MR. SCHNEIDER:

Q. I'm Richard Schneider with King and Spalding. I represent Brown & Williamson. I want to cover just a few areas with you. Hopefully, it will be interesting and short.

I want to talk first about this concept of earlier is better.

A. Sure.

Q. Now, when you say earlier is better, what you mean is you're talking about people who have cancer --

A. Yes.

Q. -- who, if it is detected, that you might be subject to be able to cure it; correct?

A. Well, there are quality of life issues other than cure that would go into making recommendations.

Q. All right.

A. So, I mean, you either want to live longer or you want to live better.
Q. All right. So when you're talking about earlier is better, you're talking about the person

that has the disease?
A. Yes. Yes.
Q. And you do something for that person to make it better?
A. That is correct.
Q. Now, you agree, Doctor, that both smokers and nonsmokers get lung cancer; correct?
A. Yes.
Q. And, in fact, you showed the jury projections and counts of cancer cases in the United States. And thousands and thousands and thousands of those cases are in nonsmokers; correct?
A. Yes, that is correct.
Q. And if you were able to find and remove a cancerous nodule in a nonsmoker and do something to make it better, that would be earlier is better for that nonsmoker; correct?
A. Yes.
Q. And if earlier is better for a smoker with disease, then earlier is better for a nonsmoker with disease; correct?
A. Yes, that is correct.
Q. And as a physician, with a duty to take care of people, you couldn't justifiably deny nonsmokers a test that you think is going to make earlier better; correct?
A. Why should I disagree with that?
And it gets back to the risk stratification concept that I raised earlier. You know, people do have different risks for different diseases. And then we make recommendations for different people in different risk categories that are appropriate for

their risk category.
Q. But if earlier is better, which has been the battle cry in this case, and the battle cry of your testimony, if that's the standard, you agree that if it's better for a smoker, it will be better for a nonsmoker as well, isn't that correct, that has the disease?
A. Actually, I didn't quite say that. I said something similar, but I didn't -- The words that you said are not the words that came from my mouth.
Q. All right. If they're similar in concept, that's good enough for me.
A. Okay.
Q. I want to go to the Japanese study or at least one of them.
A. Okay.
Q. And briefly take a look inside of it. Because yesterday you said you couldn't remember all of them. And I understand that you can't remember every article you ever read.
A. Sure.

Q. Especially someone that's read as many as you have. So I'd like to take a look and put one up and see if this refreshes your recollection. And we'll talk about it a little bit.
A. May I get a hard copy as well, please?
Q. Absolutely.
A. Thank you .
MR. SCHNEIDER:
If I could call for SA-4740.
Your Honor, may I approach?
THE COURT:

I have a copy that I can give to the witness.
MR. SCHNEIDER:
If you could put that up on the screen for witness and for counsel. I do not believe this is yet in evidence, Your Honor.
Let me ask a few foundational questions first.
MR. LEGER:
Your Honor, we have no objection.
MR. SCHNEIDER:
Then let me dispense with them.
Thank you very much, Mr. Leger.
MR. LEGER:
You're welcome.
MR. SCHNEIDER:
We can put, with Your Honor's permission, if we could publish and admit Defendants' Exhibit SA-4740.
THE COURT:
You may publish it. And it will be received in evidence.
EXAMINATION BY MR. SCHNEIDER:
Q. Now, Dr. Sartor, this is an article published in Chest magazine, July 2002; correct?
A. Yes, it is.
Q. And you recognize the Chest journal as a peer-reviewed and respected journal?
A. Yes, I do.
Q. And this is an article written by a group of Japanese scientists, the lead author being Takashi Nawa; correct?

A. Yes. This is one of those articles whose names I could not remember yesterday.
Q. All right. Fair enough.
And this is an article tracking a CT scanning study over in Japan; correct?
A. That is correct.
MR. SCHNEIDER:
All right. Now, let me ask you, Ted, if you would, just blow up that box there.
EXAMINATION BY MR. SCHNEIDER:
Q. Now, Doctor, that little box, just for the benefit of everybody in the courtroom, that's what we call an abstract; correct?
A. Yes.

Q. It's a little summary of the article so you don't have to read the whole thing but you can get to the nut of it quickly; correct?
A. Well, sort of. I don't always agree that you don't have to read the whole thing.
Q. All right. But it's meant to give a quick little snapshot of the article?
A. Yes, it does. It gives you a quick summary.
Q. We're going to look just a little bit at that and also look at something in the article as well. But let's look at this first for a moment.
They were using CT helical scans. And that's what we've been talking about in this courtroom?
A. That's right. The spiral CT, that's correct.
Q. And they gave the CT scan to 7,956 individuals; correct?
A. Yes, they did.
Q. And of those 7,956 individuals, they found

2,865 nodules; correct?
A. Well, actually the noncalcified nodules.
Q. There were 2,865 of those?
A. Right. Noncalcified SPNs, which is the solitary pulmonary nodules.
Q. The solitary pulmonary nodules that we were talking about earlier in your testimony?
A. Yes. SPNs, that's correct.
Q. All right. If you read on in the abstract, they say after doing CT scans of 7,956 people, they found 2,865 SPNs or these nodules. And of those, 40, 40 were cancer; correct?
A. That is correct.
Q. And of those 40 cancers, 17 were smokers. Do you see that there? Current or former smokers represented only 17 of the 40 cases.
A. Yes. Yes, "Current --" Yeah, on down a little bit, "Current or former smokers represented only 17 of 40 cases."
Q. All right. So 23 of the 40 cases were nonsmokers?
A. Yes, that is correct.
Q. All right. Now, Doctor, let's comment on those numbers for just a moment. Let me just ask you a few questions about them.
A. Okay.
MR. SCHNEIDER:
Ted, if you would go to Page -- three pages into the article where it says, "Prevalence of SPNs at Baseline Screening."
And, Your Honor, may I publish that page?

THE COURT:
You may publish it.
MR. SCHNEIDER:
Ted, if you'll highlight that paragraph there.
MR. TED MILLER:
The entire paragraph?

MR. SCHNEIDER:
Yes, go ahead. Blow that up.
EXAMINATION BY MR. SCHNEIDER:
Q. And here it says, "During the baseline screening...."
Would you agree with me that what that means is during these CT scans that they were doing?
A. Well, for the first time. That's what they mean by "baseline."
Q. And that's the 7,900 people; correct?
A. Yes.
Q. 7,956?
A. Yes, that's correct.
Q. All right. And again they say, "A total of 2,865 noncalcified SPNs," and I'll just shorten that to nodules, "were found."
And those 2,865 nodules were found in 2,099 patients; right?
A. Yes.
Q. And of those, as we said earlier, 40 of the patients actually had cancer?
A. Yes, that is correct.
Q. So this test, out of 7,000 plus people found 2,099 nodules, only 40 of which were cancerous. That means 2,059 of those 2,099 were not cancerous;

correct?
A. No, not necessarily. Because I would suspect a number of them were indeterminate.
Q. All right. But of the 2,099 that were identified, 40 of them had cancer. Approximately 2,059 out of the 2,099 identified were not identified specifically as cancer; correct?
A. Yes, at the time of this report, that is correct.
Q. And some people refer to that figure, as you were saying earlier, as a false positive figure?
A. Some people would refer to it that way, yes.
Q. And if some people had a calculator and divided 2,059 by 2,099, that would be a 98 percent false positive rate; correct?
A. I'm going to assume those numbers are pretty correct.
Q. All right. I did the calculation myself.
A. Okay.
Q. But on a calculator.
Now, according to an article you were reading earlier today, you were talking about earlier today, the recommended procedure currently in the United States, if you were identified with a nodule, is to do wedge resection surgery; correct?
A. No. No. It -- There -- I don't think anyone, anyone, would recommend looking at a noncalcified SPN on a CAT scan and going straight to wedge resection. I do not believe that it said that.
Q. All right. I'm going to pull that up here.
A. I remember it pretty well. If you'd like me

to take a shot at it from memory, I'm not afraid to.
Q. No, that would be fine. Let me direct your attention to --
A. Well, let me point out the distinction.
It's between solitary pulmonary nodules, between noncalcified solitary pulmonary nodules and the methodology of detection, which in the Chest article was not specified. They only referred to SPNs. They did not refer to noncalcified SPNs detected on a CT scan.
No responsible organization, unless you're implying that organization is remarkably unresponsible, would make a recommendation to go in and do chest surgery on all of those patients.
Q. So some proportion of those SPNs would be -- Because the recommendation you were reading this morning said, "Inoperable patients with an SPN, an SPN, if that lesion is amenable to wedge resection, then wedge resection is the procedure of choice"; correct?
A. That is what it said. Actually, I remember that. And I made note of what a remarkable recommendation that would be if you wanted to operate excessively. Perhaps these are written by greedy chest surgeons or something like that, but -- No, I mean, let's be serious. That does not apply to these studies. And I will -- I will challenge anyone who says that it does because that simply is not correct.
Q. Well, let's do be serious, Doctor.
A. Okay.
Q. That article that you're referring to,

LR-2295 entitled "The Solitary Pulmonary Nodule" was published in the Chest magazine, which is the Journal of the American Chest Physicians. And they --
A. Yes.
Q. -- made the very statement that we've been discussing; correct?
A. They talked about solitary pulmonary nodules, the SPNs. They did not refer to the mechanism whereby those nodules were detected nor did they make reference to the calcification aspects of those nodules.
Furthermore, as I referred to this morning, that would suggest that there are better ways that that can be addressed. And my understanding is that there might be another witness to follow me who might also have something to say about that recommendation.
MR. SCHNEIDER:
Let me direct your attention to Page 19 of this article. Ted, it's the last page of the article.
And, Your Honor, may we publish that page?
THE COURT:
Yes.
EXAMINATION BY MR. SCHNEIDER:
Q. Now, before we go to the specific portion,

I want to talk a little bit about types of cancer briefly with you, Doctor. There are various types of cancer of the lung; correct?
A. Yes, that is correct.

Q. And one type of cancer of the lung is squamous cell cancer of the lung; correct?
A. That is one type.
Q. And another is small cell carcinoma of the lung; correct?
A. That is another type.
Q. And those two particular types of cancer are very associated with smoking; correct?
A. Yes, they are.
Q. Now, there are other types of cancers? Adenocarcinoma; correct?
A. Yes.
Q. And a subspecies called bronchioloalveolar carcinoma; correct?
A. Yes, that is correct.
Q. That latter cancer, bronchioloalveolar carcinoma, is considered to be less associated with smoking than, say, squamous and small cell; correct?
A. Yes, that is correct.
Q. All right. And, in fact, a substantial percentage of the bronchioloalveolar carcinomas detected in the country in modern times are in nonsmokers; correct? Never-smokers?
A. That is correct.
Q. All right. Now, Doctor, in this study in Japan, when they did CT screenings to 7,900 people, they found zero squamous cells and small cell cancers?
And if you could blow up the top of that paragraph there, Ted, you see there, Doctor, where it says, "As described previously, the target of thoracic CT screening is peripheral lung cancers.

Although squamous cell carcinoma and small cell carcinoma are strongly related to smoking, these central early-stage lung cancers may not be detected by CT screening. We could detect no cases of squamous cell carcinoma --"
A. I'm sorry.
Q. I'm sorry. Ted, blow up some more. I'm getting too far there.
It says, "We could detect no cases of squamous cell carcinoma or small cell carcinoma by our CT screening."
No cases out of 7,900; correct?
A. That is correct.
Q. All right. But it did make an interesting observation: That of the 40 cancers that it detected, 23 of them were in nonsmokers and 17 were in smokers?
And so it said, given that, if CT scanning is to be recommended, it should be recommended for both smokers and nonsmokers; correct? Doesn't that article say that?

A. The article says that.
And, you know, it was very, very interesting, these results. It was -- This group of patients was not a population-based group. They happened to be covered in the Hitachi employees health insurance group. It was also known Hitachi scanners.
What they seemed to find was that their nonsmokers had a risk of lung cancer that was as high, or perhaps even higher, than their smokers. This is a very strange population. And I would wonder whether or not these results would be

representative of those found in other areas, number one; and, number two, I would be very concerned about a possible toxic exposure within this group of industrial workers.
Q. Well, Doctor, in fact, we noticed in that quote that CT screening detects best peripheral lung cancers; correct?
A. Yes, we've -- I think there's general agreement on that.
Q. And that would be adenocarcinoma and bronchioloalveolar carcinoma; correct?
A. Yes, that would be correct.
Q. And is it not correct that even in the United States, when you take a look at the group of people that have bronchioloalveolar carcinomas, a substantial percentage, 20, 30, 40 percent of those could be never-smokers; correct?
A. Yes, that is correct.
Q. So it could readily be the case that you test a group of both smokers and nonsmokers and get the same kind of results they got in Japan? That when you find adenocarcinomas and bronchioloalveolar carcinomas, it might be 50 percent nonsmokers, 50 percent smokers; correct? It could be?
A. Of course, it could be.
Q. And if that is the case -- I'm sorry.
A. Well, I would just point out that given the association between cigarette smoking and lung cancer, which has been established literally for decades, that it would be a very surprising result. Now, it could be. And I would actually regard this finding as a bit of a surprising result.

Q. And it's one that would caution a physician who would say we need to adopt this test to come to court and say, well, it should only be for smokers? When we know there are thousands of nonsmokers that get cancer, when we know there's a study out there that says it detected 50/50, roughly, you'd have to think long and hard before you came in and said this should be a test only for smokers; correct?
A. Well, actually, I don't have to think that long and hard. I feel pretty confident even today. You know, the data on smoking and cigarettes and smoking cigarettes and lung cancer is so well-established, I quoted the data as being 87 percent.
So it is pretty hard for me to look at

smokers and nonsmokers as being in the same risk category, which has been one of the themes that I've tried to develop during my testimony.
Q. Well, Doctor, it may be the case that smokers have a far higher rate of squamous cell lung cancer and small cell cancer, but that's not what CT scanning detects; correct?
A. Well, you know, we can't look at absolutes here. It's, you know, again, this is a small study. And it turns out that there were no small cells and no squamous. However, if we come to the American studies, there are small cells and there are squamous, which sort of is more typical of what we would expect.
MR. SCHNEIDER:
Let me ask you, Ted, if you could take a look on this same page, down at the bottom of the middle paragraph there, if you would just

highlight that and blow that up?
EXAMINATION BY MR. SCHNEIDER:
Q. Do you see that it says, "Thus, women and nonsmokers should not be excluded from CT screening. We recommend that both men and women nonsmokers in excess of 50 years of age participate in the baseline CT screening."
Do you see that?
A. Yes, I do.
Q. Now, Doctor, I want to ask you about this principal of earlier is better just from a little different focus. And a couple more questions, maybe ten questions or so, and we'll be done.
A. Sure.
Q. Which under the Judge's rule, I probably should triple to 30, but --
Assume you have 7,000 smokers. Assume you have 7,000 smokers, all right? This is a hypothetical.
A. Sure.
Q. And let's assume you find nodules in 3,000 of those patients. You do the CT scan, you find nodules in 3,000 of them.
A. Sure.
Q. And let's suppose of those 3,000, you find five cancers.
A. That would be surprisingly low. I mean, the Henschke data was, of course, you know, over two percent in their initial screen. And the Mayo Clinic also came up with a two and a fraction percent in their latest data, which we haven't had a chance to look at.

Q. All right. But just for the purposes of illustrating the point we're going to talk about --
A. Sure.
Q. -- just accept for the moment that you have 7,000 people you screen, you have 3,000 you find nodules, and of those 3,000 you find five cancers, okay?

A. Well, that is, indeed, a hypothetical case.
Q. Very hypothetical.
A. Very hypothetical.
Q. You find five cancers.
And let's suppose those people would have died but for doing the CT test, but that you do some surgery and you save those five people.
A. Yes.
Q. All right?
A. Yes.
Q. Assume that.
A. This is a hypothetical case.
Q. Now, let's also assume that of those 3,000 nodules that you found, that because of the recommendations of physicians in this country, the chest physicians we're going to come back to --
A. I'd be glad to come back to that.
Q. We're going to come back to it.
-- that you do surgery not on 3,000 but you do surgery on, let's say, 500 of those people to remove the nodule you found in those individuals.
A. That would be a group of irresponsible physicians, sir.
Q. All right. Assume with me --
A. You'd be operating on 500 to find five

cancers? I mean, that's even outside the range of hypothetical.
Q. Well, we're inside a hypothetical.
A. Well, no, this is not hypothetical. I cannot agree to go here.
Q. You can't? Okay.
A. No. No, I cannot operate on 500 people and find five cancers. There would be malpractice littered everywhere. And I don't want to even hypothetically get involved in that.
Q. All right. Doctor, you understand that the problem of false positives is that you do surgeries in the search for potential cancer and cause problems and harm to the patient. Now, you don't have --
A. Yes, I think that's a good use of the term "false positive," by the way. Those individuals you do invasive tests on and you do not find cancer, that's a good definition of "false positive," one we agree upon.
Q. All right. And you can imagine, Doctor, you don't have to say that it would be malpractice or anything else terrible, to imagine that you did a hundred thoracotomies, and you had some deaths as a result of those thoracotomies, people who did not have cancer but they died simply as a result of complications from the procedure. You can accept that that would be a possibility; correct?
A. We are in a very hypothetical area. I'm certainly not an expert on thoracotomies. However, about one percent of a mortality rate following thoracotomy would be more familiar -- well, that

would be within the familiar range for me.
Q. All right. So one percent.
So if you took a thousand cases of thoracotomy, one percent death rate in that group would be?
A. Ten.
Q. Ten.
Now, Doctor, would you agree in a screening procedure, under our hypothetical, and I understand you're stretching to reach with me there --
A. I'm not with you on that 500 surgeries and five cancers.
Q. I understand.
A. I'm just not there.
Q. But if you have a screening procedure that finds five cases of cancer --
A. Yes.
Q. -- and as a result of the screening procedure, those five people live, do not die --
A. Yes.
Q. -- but, also, as a result of the screening procedure, ten people die during thoracotomies --
A. That would be a bad screening procedure.
Q. Exactly.
-- you would then have a screening procedure which, for the overall group, ten people died with the screening; whereas, without it, five people would have died?
And do you agree, Doctor, that under that scenario, for that group, earlier is not better; correct?
A. I would agree that under that hypothetical

case, which probably involved malpractice, which I tried to distance myself from, that that could occur.
Q. All right. Now, Doctor, I think you've told the jury that you did not see Gloria Scott; correct?
A. No, I did not see Gloria Scott.
Q. And you've not seen Deania Jackson?
A. No, I have not.
Q. In fact, when you were on a plane or got a call and they told you the name of Walter Leger, you had never heard of him --
A. I was in the clinic.
Q. -- he became your patient, in effect?
And you developed a program to try to meet the legal requirements of this case; correct?
A. No. No.
Q. All right. Well, Doctor, let me ask you this. When you consulted with that group of doctors that you talked about on direct, they didn't ask you, "Hey, Doctor, tell us what programs, what screening tests have been recommended for smokers" because the answer to that would have been "None"?
A. They did not ask me to look at that. They gave me a series of criteria and asked me whether or not it were possible to devise early detection tests that might provide medical benefit within groups of individuals at high risk.
Q. All right, Doctor, just a few more questions.

Let me ask you a question about The Guide to Clinical Preventive Services.
A. Yes, the 1996 version, the one that doesn't include prostate cancer, that one that even today

their current recommendations thinks that we need to do more studies for prostate cancer.
That's the one?
Q. I'm sure that wasn't my question, but we'll go ahead. Doctor, you remember you were talking about criteria and you were referring to a letter system: A, B, C and D.
Do you recall that?
A. Yes.
Q. And you were shown a recommendation from this text marked as a Recommendation D; correct?
A. That's correct.
Q. And you said what that meant was that whoever made this recommendation, that meant they weren't very sure of themselves?
A. Well, generally, the A recommendations -- and those would be true for other societies -- I know the A recommendation is a strong recommendation, the B is less, the C is less, and the D is even less, that is correct. That's the typical grading system, just like we, you know, have in grade school, high school and everywhere else.
Q. Yes.
But what you said to the jury, Doctor, was that if it said a letter D, that meant whoever came to that conclusion, like not recommending TTNA, that they just -- they made the recommendation but, you know, they weren't very sure of themselves so they put down a D?
A. Yeah, they graded their recommendations according to the level of confidence in them.
Q. All right. Now, have you, in fact, looked at

the letter grading scale in this book, that doesn't contain the prostate recommendation, called The Guide to Clinical Preventive Services put out by the United States Preventive Task Force, have you actually looked at the rating system that's in here?
A. No, I did not. But I made the assumption it would be like the other ones.
Q. All right. Now, Doctor, I'm going to show you Page 861. And ask you if you could take a look at what the criteria mean, particularly Criterion D.
A. I'd be glad to.
THE COURT:
Yes, you may approach the witness.
MR. LEGER:
Counsel, do you have a copy?
MR. SCHNEIDER:
I'm sorry, Your Honor.
MR. LEGER:
Do you have a copy that we can look at?
MR. SCHNEIDER:
I don't. I'll show it to you before I

ask him a question.

MR. LEGER:

Okay.

THE WITNESS:

Yes, I have A, B, C, D and E right here in front of me.

MR. SCHNEIDER:

Your Honor, may I get that and show that briefly to Mr. Leger?

THE COURT:

Yes, you may.

MR. LEGER:

Thank you.

MR. SCHNEIDER:

Your Honor, may I once again approach and provide the doctor with the text?

THE COURT:

Yes.

EXAMINATION BY MR. SCHNEIDER:

Q. Now, Dr. Sartor, could you tell us what they put down as the meaning of the code letter D in The Guide to Clinical Preventive Services?

A. Sure.

Q. What does it say?

A. It says, "There is fair evidence...." And they use other terminologies such as "good" in their A level. A is "good."

D, it says, "There is fair evidence to support the recommendation that the condition be excluded from consideration in a periodic health exam."

Now, does this refer, my understanding is, to the asymptomatic individual who is probably not at any excessive risk.

MR. SCHNEIDER:

All right. Let me ask you, Ted, if you could pull up LR-2295. Which, I believe, was admitted this morning, Your Honor. Let me pull it up.

MR. LEGER:

That's correct, Your Honor.

THE COURT:

It's in evidence. Proceed.

MR. SCHNEIDER:

If you could pull up the page that refers to wedge resection, which is Page 935 of the article. You can go ahead and publish it on the screen.

May we publish it, Your Honor?

THE COURT:

You may publish it.

EXAMINATION BY MR. SCHNEIDER:

Q. And if you would look down at the bottom where it says "SURGERY" in the left-hand column, that sentence down there. And that sentence as well.

This is talking about recommendations for

what you do when you detect a solitary pulmonary nodule; correct?
A. Yes, that is correct.
Q. And it says, "The patient with an SPN that is new and does not have benign appearing calcifications...."
Correct?
A. Yes, that is correct.
Q. "...should be considered to have a malignancy until proven otherwise"; correct?
A. That is what they say.
Q. So that's basically referring to the noncalcified solitary pulmonary nodules; correct?
A. It does appear that way.
Q. All right. Now, Doctor, I think that this is clear. But it's certainly the case, is it not, that you certainly have not written a prescription, formally prescribing for every person who ever

smoked a cigarette, prior to May 1996, prescribing for those individuals a bladder cancer test and a CT scan? You certainly have not written such a prescription; correct?
A. No. No, I've not written such a prescription.
MR. SCHNEIDER:
Thank you, Doctor. No further questions.
THE COURT:
Any other cross of this witness?
MR. LONG:
No, Your Honor.
THE COURT:
We'll take our midafternoon recess until ten after 3:00 by the wall clock.
THE WITNESS:
May I ask a question to you?
THE COURT:
When the jury leaves.
(Whereupon the jury is excused at this time.)
THE COURT:
The jury has left the courtroom.
Anything for the record by plaintiffs' counsel?
MR. LEGER:
No, Your Honor.
THE COURT:
Defendants?
MR. WITTMANN:
No, Your Honor.

THE COURT:
Doctor, you wanted to ask me a question?
THE WITNESS:
Yes. It was a simple question.
I had a little confusion about whether or not I could talk to attorneys during the break. And somebody said "Yes" and then

somebody said "No." And I think the answer is --

THE COURT:

The objection to that has been withdrawn, so you can do that.

THE WITNESS:

Okay. Thank you.

(Whereupon a brief recess was taken at this time from 2:57 o'clock p.m. to 3:10 o'clock p.m.)

THE BAILIFF:

All rise for the jury, please.

(Whereupon the jury joins the proceedings at this time.)

THE LAW CLERK:

Recess is over. Court will come to order.

THE COURT:

Please be seated.

Any questions on redirect, Mr. Leger?

MR. LEGER:

Yes, Your Honor, I do have some questions. Without giving you the number.

THE SPECIAL MASTER:

Microphone.

REDIRECT EXAMINATION

BY MR. LEGER:

Q. Dr. Sartor, you've talked to me a few times; haven't you?

A. Yes, sir.

Q. You know I have a tendency to talk fast sometimes?

A. I've seen you do that.

Q. Slow me down if you need to, but I am going to try to get through this pretty quickly and as briefly as possible. And promise me you won't let me, you know, get off track. You keep me focused and make me answer the question that you need me to answer for you, all right?

A. I won't let you put any words in my mouth.

Q. I don't think you will, Dr. Sartor. And that's what I want -- I want to make sure you don't do that. Is that all right?

A. I'm under sworn testimony.

Q. Thank you.

This Guide to Clinical Preventive Services that they've been talking to you about for the last hour or so, you remember this was published in 1996?

A. I pointed that out.

Q. And you remember -- And would that mean that basically the data in this book is derived from data that was available through 1995?

A. That would be a reasonable assumption.

Q. So that's about eight years ago; correct?

A. That is correct.

Q. Now, there's nothing in here that -- at least in the materials that the lawyers for the cigarette

companies went over regarding this NMP-22 test that you recommended with respect to bladder cancer screening; is that right?
A. That is correct.
Q. The recommendations regarding bladder cancer screening didn't even take into account the existence of a test called NMP-22, which had been approved for use by the FDA, because it hadn't been at that time; right?
A. Well, in 1996, when that book was published, I doubt if they would have known about the NMP-22. Certainly, the approval letter for the early detection of bladder cancer and NMP-22 was in the year 2000.
Q. And the approval letter with respect to the use of NMP-22 by the Food and Drug Administration of the United States was published in the year 2000 for the use of NMP-22 for the early detection of cancer in people at high risk for cigarette -- I'm sorry, at high risk for bladder cancer; right?
A. Right.
But, I mean, let me make sure that there is some additional language. It was in conjunction with, not in lieu of. I remember the language very clearly.
Q. And, Doctor, you specifically have recommended a systematic procedure of the narrowing of risk populations, you call it risk stratification?
A. Yes.
Q. Right?
A. Yes.

Q. By the use of various procedures which would eventually keep identifying higher risk populations for bladder cancer?
A. Right.
Without having to do invasive testing on everybody, I was very careful in my recommendations.
Q. This book, The Guide to Clinical Preventive Services, Second Edition, that they talked to you about, also didn't take into account, with respect to lung cancer screening, the data regarding the effectiveness and the use of low dose spiral CT in the early detection of lung cancer screening; correct?
A. No. There had been no published studies in America at that time.
Q. In fact, the leading published article regarding the use of low dose spiral CT for the early detection of lung cancer didn't come out until about 1999; is that correct?
A. That is correct.
Q. That was publication of the International Early Lung Cancer Action Project studies involving Dr. Claudia Henschke; correct?
A. What we call the ELCAP studies. That was the initial ELCAP publication was in 1999 in a Lancet article.
Q. Now, Doctor, you also appeared to be quibbling a little bit when you were looking at

these Dr. Smith's ACS guidelines published in 2003; is that right?
A. Well, yes.
And the reason I found it a little bit

puzzling is that I had, you know, remembered personally looking at things and seeing it dated in 2003 which weren't in there.
And I tried to make that clear to the jury that these were some recommendations. I was not at all clear if that recommended all that was available. And, hopefully, I was clear in doing that.
Q. You don't mind, Doctor, if I remember something that you didn't remember?
A. You know, you spend all your life looking at these documents. And I don't.
Q. You don't mind if I do?
A. No, I don't mind if you show something.
Q. Doctor, may I show you a document that we talked about, it seems like a week ago, I think it was just yesterday, Exhibit Number 1410 -- I'm sorry, 1410.02, Your Honor, which was offered and entered into evidence yesterday?
And, Doctor, I have my own little pointer today. Do you have one there?
A. I have one. I was getting ready.
MR. LEGER:
May we publish, Your Honor?
THE COURT:
You may publish it.
EXAMINATION BY MR. LEGER:
Q. Doctor, do you remember this?
A. Yes. Yes, this is the one that we looked at yesterday. And this is from the American Cancer Society.
Q. And this was taken -- I'm sorry.

A. Well, I was checking the dates. I've learned I have to check dates pretty carefully. This is a 2003 document.
MR. LEGER:
And can we highlight this aspect right here? And blow it up, please.
EXAMINATION BY MR. LEGER:
Q. This is the American Cancer Society in 2003, this year, correct, Doctor, on their website?
A. Yes. I mean, what I have -- and it's on the pages -- is it's actually dated March 12th, 2003. That March 12th, of course, would have been, you know -- what? -- eight days ago or thereabouts.
Q. Okay. And that's a page on the Internet that when you get on the computer and you do all your clicking and you get on the Internet, this page comes up on the American Cancer Society website; correct, Doctor?
A. That is correct. This is from the American Cancer Society website.
Q. Doctors, physicians, scientists, lay people,

even lawyers, can find this on the website; correct?
A. If they look.
Q. Okay. And, Doctor, tell us what does that say about the early detection of bladder cancer?
A. Well, I mean, we did cover it yesterday, but -- And I'll be very brief.
Q. Summarize it then.
A. Well, basically, you can find -- bladder cancer can sometimes be found early. I mean, if you find it early, it improves the chances that it can be treated successfully.

And then it goes on to say, "Unless you have strong risk factors that would justify a special screening," implying that if you do have strong risk factors, that you are justified in having special screening. The best advice is to see your doctor right away.
But, you know, the bottom line is that this is from the March 12th information, 2003, that I have.
Q. That American Cancer Society says if you have a strong risk factor, cigarette smoking is a strong risk factor; correct?
A. Yes. I think there's been general agreement by everyone on that point.
Q. Then that would justify a special screening test; right, Doctor?
A. I believe that it would.
MR. LEGER:
Okay. Take that off, please.
No, I just meant the thing that was blown up.
Would you put the document back up? I'm sorry.
Can we go to this paragraph right here, the one that says, "If there is...."
And then bring it all the way down, bring it all the way down and blow it up, please.

EXAMINATION BY MR. LEGER:
Q. It says, Doctor, "If there is a reason to suspect you might have bladder cancer, the doctor will use one or more...."
I'm sorry. Right before that, Doctor. Do

you have a hard copy there?
A. Yes, I do.
Q. So just to save time, the paragraph before, please read that sentence. There we go.
A. I'd prefer it be up on the board to make, you know -- That's just my preference.
Q. Fine. Read that.
A. Okay. "Blood in the urine or changes in bladder habits can be signs of bladder cancers."
Q. You recommend looking for blood in the urine in people with strong risk factors; correct?
A. That is exactly what I'd recommend.
Q. The American Cancer Society recommends looking for blood in the urine in people with strong

risk factors; correct?
A. Well, they don't -- Previously, the special screening tests are justified in high-risk populations. And then it goes on to say that blood in the urine can be signs of bladder cancer. And there was no disagreement on that issue.
Q. Right.
And then it says, "If there is a reason to suspect you might have bladder cancer, the doctor will use one or more of the methods below to find out if the disease is really present"; correct?
A. That is correct.
Q. And it says -- And among those are medical history and physical exam?
A. Yes.
Q. Urine cytology? That's one you recommend; correct, Doctor?
A. Yes. The urine cytology was recommended in

the report that I prepared earlier.
Q. Urine culture? Cystoscopy?
A. Well, I mean, this urine culture is one I mentioned a little bit earlier as well. I mean, you know, if you have white cells in your urine -- and I just want to, you know, read this -- that, you know, "A sample of your urine is sent to the lab to see if you might have an infection. Infections can sometimes cause symptoms like those of bladder cancer." That's exactly what I said.
Q. Cystoscopy, you don't recommend cystoscopy unless you do two tests, one or more; right?
A. That is correct. And, I mean, you know, to go back to the language up here, we're looking at two or more of these tests.
MR. LEGER:
The next page, please, if you would, Carl. The second page.
May we publish, Judge?
THE COURT:
You may publish.
EXAMINATION BY MR. LEGER:
Q. And it says right there, "Bladder Tumor Markers" and "Imaging Tests"; correct?
A. Right, "Bladder Tumor Markers" and then "Imaging Tests."
MR. LEGER:
You can take that down, please. Unpublish it.
EXAMINATION BY MR. LEGER:
Q. So, Doctor, is it fair to say that -- And we talked about the bladder tumor marker series that

you recommended as being unique because it had been approved after testing and submission to the Food and Drug Administration for use in the early detection in high-risk populations in the detection of bladder cancer; right?
A. Well, that carried additional weight for me. You know, when you look at the FDA and they cast

value on something, then it's pretty good; but if they never evaluate something, then there is no way that they can make the comment.
Q. So, Doctor, with respect to these recommendations, they do exist, like you were trying to find in your head?
A. Well, yes. I mean, well, quite frankly, I was a little bit puzzled when I was reading that article this morning because I knew there was more to it. And this is the part that was more to it. And, again, I've explained to the jury that, you know, I cannot remember everything. And I hope neither myself nor anyone else is held to that standard.
Q. And, Doctor, as far as you know, these recommendations that the American Cancer Society has today may not have existed in 1995 when the doctors were doing their homework to put this together to be published in 1996; correct?
A. Well, there's no way that it could have.
Q. Doctor, do you prescribe this systematic use of urinalysis, then if you find blood in the urine, the use of cytology and NMP-22 for the early detection and monitoring for the early detection of bladder cancer?

A. In high-risk patients, I do.
Q. And is part of that design to keep from going into that invasive procedure we heard about where they stick a tube in you where you don't want a tube being stuck in you?
A. I was actually very precise in the way that I designed it. You know, even though I don't think cystoscopy is likely to cause substantial harm to a patient in terms of their death, or anything like that, it nevertheless is uncomfortable and it is invasive.
So what I designed was a progressive series of risk stratifications, taking into account age and risk factors that are known to be the most important cause of cancer today in American bladder patients, cigarette smoking, looking for blood in the urine, which is not a perfect test but which serves to risk stratify people, and then taking those individuals and doing the FDA-approved test and a traditional test called cytology.
And, by the way, there are data to show that using those two tests in combination lead to a higher sensitivity prior to sending people to cystoscopy. Because I did not want everybody to go to cystoscopy. Just in the same way that I don't want everybody to go to surgery.
Q. We don't want to go, either, Doctor.
A. Well, no.
Q. Right?
A. I mean, I want to do it when it is medically appropriate to do so. I did put my recommendations down on paper.

Q. And, Doctor, --
A. And I defend those recommendations.
Q. And those continue to be your recommendations; correct, Doctor?
A. Those were my recommendations then, they are my recommendations today.
Q. Now, Doctor, just real briefly, do you remember the last lawyer for the cigarette company talked to you about --
MR. GAY:
Objection.
THE COURT:
Overruled. Finish your question, please.
EXAMINATION BY MR. LEGER:
Q. -- talked to you about the issue of whether, once you find a small pulmonary nodule in the chest, it's appropriate to go straight to surgery and do a wedge resection; is that correct?
A. Well, they --
Q. "Yes" or "No," Doctor?
A. Yes.
Q. I'm going to try to get us through this quick, if you would, if you don't mind.
A. Okay. I'm sorry.
Q. Is that what he was talking to you about?
A. Yes.
Q. Suggesting that that was appropriate?
A. Yes.
Q. And that there's a recommendation from some surgeons that that's appropriate? Is a wedge resection where you take a chunk of the -- a little

piece of the lung out?
A. Yes, it is.
Q. Doctor, are there also recommendations by other doctors in the peer-reviewed literature, by other physicians in the peer-reviewed literature, for taking steps before, just because you find a nodule on the lung, for taking steps before that, before you open up the person's chest?
A. Absolutely.
Q. And have you seen those?
A. Of course, I have.
Q. And have you identified those and have you brought any of those to court here with you today?
A. Yes, I did.
MR. LEGER:
Now, Your Honor, if I may, we have two articles, not expecting this, that have not been identified as exhibits. I will not offer them into evidence. But I would ask that the doctor be able to read from them, if that's all right.
THE COURT:
That sounds like a prospective ruling. Why don't you ask the witness a question, please.
MR. LEGER:
Okay. I'll do that.
EXAMINATION BY MR. LEGER:

Q. Doctor, have you taken a look at the literature and, at your direction, your staff or mine, obtained two articles from the peer-reviewed literature?

A. I don't want to put this on any staff member. I personally pulled these articles.
Q. I'm sorry. I'm sorry.
And can you tell us what you found? Is one of those articles in the peer-reviewed literature from a guy named Dr. Edward F. Patz, M.D.?
A. Yes.
Q. And --
MR. SCHNEIDER:
Objection, Your Honor. May we approach?
MR. RUSS HERMAN:
May we approach, Your Honor?
THE COURT:
Yes.
MR. LEGER:
Your Honor, I'll withdraw it. I'll withdraw it.
Never mind, Your Honor, I'm going to reoffer it. The older guy gave me advice.
MR. RUSS HERMAN:
The short fat one, Your Honor.
MR. LEGER:
A little bit taller.
(Whereupon a bench conference is held at this time as follows:)
THE COURT:
This is new stuff on redirect. There's going to be a request for recross.
MR. RUSS HERMAN:
You can't put it on an exhibit list until you have the cross and know what's going to come up on cross. And this came

up with Burns, it's come up before. And the redirect evidence comes in if he can establish a basis for it. We can't anticipate --
THE COURT:
The rules require if new matter is allowed to be brought up on redirect, I should allow recross.
MR. BELASIC:
And I think we should at least be able to get a copy so we can read the new matter.
MR. LEGER:
Yes. I'm sorry.
MR. BELASIC:
I don't want to take your copy.
THE COURT:
Ask your question if you're interested in asking your question.
(Whereupon the bench conference is concluded at this time.)
MR. LEGER:

Your Honor, never mind. I'll withdraw the offer of the use of this exhibit.

EXAMINATION BY MR. LEGER:

Q. Doctor, have you gotten a look at the data?

A. Yes, I have copies.

Q. Put it down. Put it down.

A. Okay. Sorry.

Q. Put it down. I want to know if you've looked at data --

A. Yes, I did.

Q. -- that tells you that there are

recommendations with respect to the use of procedures that, other than surgery, once you find a small pulmonary nodule or a solitary pulmonary nodule, the use of procedures before you go directly to surgery and open the chest of a human being up?

A. Of course, there are.

Q. And what are those recommendations, Doctor?

A. Well, one of those recommendations is that a noninvasive imaging test called a PET scan, that's positron emission tomography --

Q. That's a new technology; right? Relatively?

A. It's a relatively newer technology. There are a couple here in New Orleans now. But it's been around -- Can I mention Dr. Patz's name?

Q. Sure. You already have.

A. Okay. You know, Dr. Patz is at Duke. And he's in the Radiology Department. He would have access to these things.

Dr. Patz has studied -- Bottom line is there is data to show that if you run PET scans on these solitary pulmonary nodules, one centimeter or greater in size, that you have the ability to stratify people into cancer, noncancer categories with a relatively high degree of accuracy; thus -- and this is some of the language -- avoiding unnecessary invasive procedures.

Q. Okay. Doctor, briefly, is there also data that suggests that you should do something else other than a PET scan before you open a person up once you find the nodule before going to surgery?

A. Yes.

Q. What's that?

A. Well, I mean, first of all -- And I want to be careful here because we could be led down a path that would lead to unnecessary surgery, which I am not advocating.

Q. And I'm not, either.

A. Right.

I mean, I want to use my words and I want to use them carefully. When you run into an indeterminate nodule, there are, first of all, a series of follow-up tests that are recommended, according to anyone who has been putting together these, including the Mayo Clinic, that may involve regrowth or growth of the nodule over a period of time; there are components of the nodule that may be

examined, otherwise known as solid or nonsolid, and have been published in the peer-reviewed literature; there have been antibiotic regimens, just like you might treat somebody's urine, you might treat and find that some of the nodules go away. And guess what? You treat with antibiotics and some of these indeterminate nodules go away. There are a variety of ways that you can stratify people into high or low risk categories.

Now, if you end up in a high risk category, it may be necessary to do an invasive procedure. For instance, you may need to put a needle into the chest, into the nodule, and draw out cells. These tests have been published in the peer-reviewed literature and have a very high degree of sensitivity and specificity.

In fact, in the Claudia Henschke study, 28 times it was deemed necessary that this be done; 27

times cancer was found. Let me repeat that: 27 out of 28. We had a hypothetical situation in which the lawyers wanted me to operate on 500 people to find five cancers.

The facts are, the data are, from the New York ELCAP study, there were 28 cases that they stuck a needle in somebody's chest and they were right 27 times. That's what I call good risk stratification.

Q. Okay. That's about 96 percent accuracy?

A. I can't calculate it off the top of my head, but if you say so.

Q. One false positive?

A. There was one false positive in that study.

And I want to be very clear that the use of false positive to refer simply to something seen on a CAT scan, I call it an indeterminate nodule, is not a real false positive.

Q. Doctor, nobody wants a biopsy; right?

A. Not unless they have a very considerable risk of cancer.

Q. When doctors screen for breast cancer, they use mammograms; right?

A. Yes, of course.

Q. A mammogram takes kind of an image of the breast and looks for nodules in the breast; right?

A. It does.

Q. Now, once you find a nodule in the breast, that's not determinative; correct? That's not a definitive diagnosis of breast cancer if you find it on a mammogram; right?

A. No, not at all.

Q. You still have to do a needle biopsy to get tissue, give it to a laboratory technician; right?

A. But you may not even do a needle biopsy; you may order an ultrasound. That's a very common finding. Or maybe what you do is order a repeat mammogram before you go sticking needles in somebody's chest.

Q. The point is, Doctor, when you're screening, you use techniques -- Mammogram is the monitoring technique in the high-risk population or the screening technique? After that, you start trying to diagnose; right?
A. That is correct.
Q. And you try to do it, good doctors try to do it, doctors that see real patients, doctors that treat real patients, doctors that care for patients, try to do things that are least invasive to the patient; right?
A. Right.
Well, it all goes back to that risk/benefit ratio we talked about and we agreed upon earlier with the attorneys.
Q. Doctor, I'm going to move to another subject because I really want to hit some things that were important to you on the witness stand.
A. Fine.
Q. Doctor, do you remember when you were asked about an article, it was called "A Viewpoint," it was AZS-000143 for reference, "A Viewpoint" article which appeared in, I'm sure, some prestigious medical journal, Radiology in the December 2001, written by Dr. Patz.

A. I have consistently asked to look at the original articles. I mean, you know, there are too many articles for me not to have a copy of them in front of me.
Q. I don't blame you, Doctor. I feel the same way. They're piled all over.
A. Yes, I do remember this article. Yes, it was shown earlier.
Q. I'm not going to show it up there because I have a very brief question about it. If you go down to, it says, "Biologic Issues in Lung Cancer Screening," there's a Footnote 3 in the middle of that paragraph.
A. I'm sorry. I need to make sure I'm in the same place as you are.
MR. LEGER:
May I approach, Your Honor?
THE WITNESS:
Yeah, I'm having trouble finding exactly where he is.
THE COURT:
Well, why don't you give him a page number and a paragraph number and a column.
MR. LEGER:
I'm sorry. I can give him my copy.
THE WITNESS:
I'm sorry, if you could just repeat.
MR. LEGER:
The first page --
THE WITNESS:
I'm sorry, I'm trying to make sure --
MR. LEGER:

The first page, the middle of the paragraph.
THE WITNESS:
The first page.
MR. LEGER:
The middle of the paragraph.
THE WITNESS:
The middle of the paragraph.
MR. LEGER:
One, two, three, four, five, six, seven, eight, nine, ten --
THE WITNESS:
Yes. Okay. Yes, this is the one they had me -- that I read earlier. Yes. Yes, I read -- Yes, I recognize where we are.

EXAMINATION BY MR. LEGER:

Q. You were asked by one of the lawyers that -- You were asked to read this, in fact.

A. I did read it.

Q. And read it again, please. Dr. Patz says --

A. All right. This is what I read earlier.

"In one report, Reference 4, of 510 patients with T1N0M0 disease, tumors less than three centimeters at presentation, no significant relationship between small size and survival was found. Patients with three-centimeter masses had the same outcome as those with nodules smaller than one centimeter."

Q. And that was suggested to you to suggest that the peer-reviewed literature suggests that the size of the tumor has no relationship to outcome; correct?

A. I made distinct mention that there were other articles that might also be referenced.

Q. Now, Dr. Patz, in this story, I'm sorry --

A. Yes.

Q. Dr. Patz in this article --

A. Well, manuscript.

Q. -- manuscript makes a reference to a Footnote 4; right? Would you go to the back and look at Footnote 4?

A. Yes. I already did.

Q. And who does he refer to?

A. Himself.

Q. So that's his reference for the authority that there is no significant relationship between the small size and survival; correct?

A. That is correct.

Q. Himself.

Doctor, are there other articles?

A. Well, of course, there are.

MR. LEGER:
And, Your Honor, at this time I would like to demonstrate to the jury Exhibit Number 1004.01.
THE COURT:
Is it in evidence?
MR. LEGER:
I don't think so, Your Honor. That's an article --

MR. BELASIC:
Your Honor, this is in evidence. I put this in with Dr. Burns.
MR. LEGER:

I kind of thought you did.
THE COURT:
Thank you, Mr. Belasic.
MR. LEGER:
Your Honor, may we publish to the jury?
THE COURT:
You may publish it.
MR. LEGER:
Can you just kind of highlight that up there and blow that line up?

EXAMINATION BY MR. LEGER:

Q. That's an article by Dr. Patz; right?
A. Yes.
Q. And what does he say in his article?
A. Well, he makes note -- And I don't know if it's possible to show the jury the data.
Q. Would you like to look at a graph?
A. I would like for all of us to look at the data.
Q. One, two, three -- On the third page?
A. Yes, it's on the third page.
THE COURT:
You may publish it.

EXAMINATION BY MR. LEGER:

Q. What does, the article that Dr. Patz refers to, what does that say about survival data in the early detection of small lung cancer nodules -- I'm sorry, pulmonary nodules?
A. Well, now, these are all cancers. They're non-small cell lung cancers. They're also a very specific type. They're pathologic stage T1N0M0.
Now, I need to explain that because that is

the AJCC classification system.
Q. Doctor, would you mind? What does that tell us right there?
A. Oh, I'm sorry. Yes.
Q. What does that tell us?
A. Right.
Well, it tells us in the pathologic stage T1N0M0 non-small cell lung cancer patient that there is a remarkable survival after surgery. These are in months down here. And you see the survival time of 100 months, well, I think about 120 months -- I'm sorry. Hang on. We need to come on this part right here (indicating).
This is survival time right here. Let's come to about 120 months because that would be ten years. That's a good, nice, long-term study. These are the probability of survival in these patients.
A hundred percent is where you start out. That means everybody is alive at the time of surgery. And then over time, some people die. And when they do die, you notice that there is a slight

decrease during the first couple of years. During the first 50 months, there is a decrease. And then there is a flat line that extends on for a long, long time.

This indicates to me that approximately 80 percent of patients with pathologic T1N0M0 non-small cell lung cancers are alive ten years after surgery, and the fact is here you are out here (indicating) probably fifteen years after surgery.

Q. And that contrasts with the 15 percent figure we saw yesterday that we saw in terms of the normal

person who gets lung cancer?

A. Right.

Q. And who is not detected -- where it's not detected early and it's not surgically dealt with; correct?

A. Well, those are American Cancer Society statistics relative to the United States today.

Q. Now, that's Dr. Patz's numbers; right?

A. Right.

Well, one other thing I want to emphasize. We were talking about five-year survivals yesterday. That would be 48 months. So the survival curves in a typical lung cancer patient today would, by the time you hit around 50 months, would be down to be less than 15 percent.

Q. Now, Doctor, --

A. May I make one more point on this article?

Q. Whatever you need to, but we're trying to get out of here.

A. I'll be very quick.

I emphasize the N0 nature. That means no positive nature. There are other studies which show that the probability of involving the lymph nodes, this is what I call metastasis, is higher as you move larger in tumor size.

Q. So the smaller the tumor, the better you are in terms of concern about the cancer going to the lymph nodes; right?

A. Right.

This excluded patients who had spread to the lymph nodes. But there are other studies that show that, as the tumor gets bigger, it spreads earlier.

So this is an incomplete analysis of early pulmonary nodules. It only takes the node negative subset.

Q. And, Doctor, Dr. Sartor, --

MR. LEGER:

Please, can we take that down? I'd like to publish to the jury 1055.01.

THE COURT:

Is this document in evidence?

MR. LEGER:

I don't think so, Your Honor. I'm sorry. Maybe I gave the wrong number. 1055.01. May we go to the next page on the screen? Let's see if that's it. That's it.

May we publish to the jury, Your Honor?

THE COURT:
Any objection?
MR. BELASIC:
No objection, Your Honor.
THE COURT:
You may publish it.
EXAMINATION BY MR. LEGER:
Q. And, Doctor, really a very refined point that I think you wanted to make. Doctor, this is a study by a Dr. Sobue of Japan?
A. Yes.
Q. And this is published, however, in a prestigious American journal; is it not?
A. It is.
Q. Cancer?
A. That is correct.
Q. November 1, 1992; correct?
A. Yes.

Q. And the name of it is "Survival for Clinical Stage I Lung Cancer Not Surgically Treated"; correct?
A. That is correct.
Q. That means people where a small cancer tumor was found but they didn't do surgery on them; right?
A. That is correct.
Q. This Dr. Sobue is not the Dr. Sone that Mr. Belasic was talking about yesterday?
A. No. No, they're different people.
MR. LEGER:
Okay. Can we go to the, I believe it's the fourth page, please?
And, Your Honor, we'd like to publish to the jury.
THE COURT:
You may publish it.
MR. LEGER:
I'm sorry, it must be the next page.
The next page.
THE COURT:
You may publish that.
MR. LEGER:
Thank you, Your Honor.
EXAMINATION BY MR. LEGER:
Q. Doctor, you asked me to show this to the jury, this graph; correct?
A. I did.
Q. And what does that illustrate? Blow it up, please.
A. Well, first of all, we have to understand, just like the last time, what I was referring to.

I was referring to pathologic T1N0 cancer. Here, we're looking at clinical stage I cancers. These are relatively early cancers. Stage I is our lowest stage. It includes, among these, stage pathologic T1A.
Q. And that's generally less than three centimeters in size; right?

A. Right.
But these are, these are the clinical stage I. It's clinical as opposed to pathologic stage I, so there are some distinctions. Nevertheless, these are stage I lung cancers.
Q. What happens to people --
A. These are early.
Q. I'm sorry.
What happens to people if you find it early but don't operate?
A. Well, we need to look at the months after diagnosis. Here is 60 months, which would be five years. If you look at the individuals who had symptoms and were not operated on, these individuals who were not operated on, they're virtually all dead by five years. And the fact is if you come out here to ten years, I think that is one patient that is still alive. And in the article, which I did read, this patient died very shortly thereafter.
The bottom line is everybody dies from lung cancer if you don't take it out.
Q. And, Doctor, Dr. Patz's article showed that if you took it out in his study --
A. If you took it out, if you took out the stage I lung cancers in his study, that he reported in a

prestigious journal, then they had an 80 percent survival rate.
Q. And, Doctor, one more article that you asked me to show the jury.
MR. LEGER:
If we may take that down and display Article Number -- I'm sorry, Exhibit Number 1049.01.
MR. BELASIC:
No objection, Your Honor.
THE COURT:
Is the document in evidence?
MR. BELASIC:
No.
MR. LEGER:
No, Your Honor. But we would like to offer it and the others. And we will do so afterwards.
May we publish to the jury?
THE COURT:
Yes. No objection. It will be received in evidence.
MR. LEGER:
And if you would please go to Page 123 -- I'm sorry, the fourth page.
And may we publish, Your Honor?
THE COURT:
Yes.
MR. LEGER:
Would you blow up that top graph?
EXAMINATION BY MR. LEGER:
Q. First of all, this is an article by a Dr.

Martini and many others that appears in the Journal of Thoracic and Cardiovascular Surgery?
A. Yes, that is correct.
Q. And, Doctor, what does that graph tell us?
A. Well, I would like to have it blown up.
First of all, if we look at the time and months, here is five years, here is ten years (indicating). This is the probability of surviving, proportions surviving. A hundred percent means everybody is alive, and zero percent means everybody is dead.
These are lung cancers that were less than one centimeter at the time that they were operated on. And there is a 97 percent five-year survival rate and a 93 percent ten-year survival rate.
Q. How big is a centimeter?
A. A centimeter is about the size of my little fingernail.
Q. So for tumors that are detected -- Largely they can't be detected by chest X-ray except lucky at one centimeter?
A. No. Well, at one centimeter, it's more probable than not that you're not going to find it on a chest X-ray.
Q. So tumors about the diameter of your --
A. Of my little fingernail.
Q. -- of your little fingernail --
A. Yeah.
Q. -- have that kind of survival rate if you surgically remove it; right?
A. Right.
These are surgically removed cases. And the

bottom line is you have greater than 90 percent ten-year survival as opposed to the untreated where all the patients were dead without surgery.
Q. Doctor, what does that data suggest to you with respect to the prospects of the use of low-dose spiral CT in the early detection of lung cancer with respect to the prospects of survival and improvement with respect to fatality from lung cancer?
A. What it shows is that the outcome from tumors that are detected early at stages that are typical of those detected at the spiral CT screening have a survival that is remarkably different than the survival of patients who are not detected with spiral CT; and, furthermore, that resection is critical for cure.
Q. Doctor, let me ask you just a few more, not a couple but a few, a few more questions.
Doctor, is it fair to say -- There has been some discussion about whether or not there ought to be or should be or shouldn't be randomized controlled trials for the early detection of lung cancer, even a little bit about bladder cancer, before it's recommended for people in the early detection -- I'm sorry, randomized controlled trials regarding the use of CT before it's used in the early detection of lung cancer; correct?
A. Correct.
Q. Okay. Doctor, in connection with breast

cancer, were randomized controlled trials completed before it became general and accepted practice among the doctors in the United States who care for patients?

A. I actually happen to know when mammography was first introduced. It was 1913.
Q. And, Doctor, when did the first randomized controlled trial regarding mammography in the use of the detection of breast cancer begin?
A. 1963, fifty years later.
Q. Doctor, with respect to cervical cancer, have randomized controlled trials -- and the use of Pap smears, have randomized controlled trials ever been completed?
A. No randomized controlled trials for Pap smears have been reported.
Q. And, Doctor, with respect to the use of PSA for the early detection of prostate cancer, had randomized controlled trials been completed before they became generally used in the population -- with respect to the population at high risk of early detection of prostate cancer?
A. That is correct. And the FDA approved the use of PSA prior to the utilization or prior to the completion of randomized controlled trials.
Q. And is that also clear from the American Cancer Society publications of the guidelines for early detection of cancers that were published in the year 2000?
A. Yes. I don't believe that medicine rests its complete foundation on randomized controlled trials. I do not mean to say that they're not important. Randomized controlled trials are important. But many standards in medicine develop and evolve in the absence of randomized controlled trials.
MR. LEGER:

May we publish Exhibit Number 1411.02? I believe it's already in evidence.
THE COURT:
Is that document in evidence?
MR. BELASIC:
Yes, Your Honor. No objection.
THE COURT:
You may publish.
EXAMINATION BY MR. LEGER:
Q. Doctor, I'd like to go to Page -- Do you have a hard copy, Dr. Sartor?
A. I'm sorry, I do not. If it were available, that would be helpful.
MR. LEGER:
I'd like to go to the second page, please.
And ask that we may publish, Your Honor?
THE COURT:
You may publish.
EXAMINATION BY MR. LEGER:
Q. Now, Doctor, I'd like you to look through

your hard copy. And we're not, for the sake of time, we're not going to go through this.
A. I'm on the second page.
Q. And would you look at the second page, Page 28, 29, skip 29 because that's a graph, 30, 31 and count the number of columns of information that discusses breast cancer screening and mammography?
A. Well, there are two columns on each of those pages. Well, Page 29 is a table. There are two more columns on Page 30. And a column and a fraction on Page 31.

Q. And, Doctor, is it fair to say that mammography for the use of early detection of breast cancer has been recommended for a long time?
A. Yes, that is correct.
Q. And that it's been found to be safe, effective?
A. Yes. There's general consensus on that.
Q. That hasn't stopped, Doctor -- And I point you to the third paragraph, I'm sorry, the paragraph right down here at the bottom, "In last year's annual...."
Blow that up, please.
That hasn't stopped the scientific debate about the effectiveness of the use of mammograms in the early detection; is that correct, Doctor?
A. That is correct.
Q. In fact, what we're looking at right now says, "In particular, a Cochrane Collaboration Review on screening for breast cancer with mammography concluded that there was no reliable scientific evidence that screening for breast cancer reduces mortality."
Is that what it says?
A. That's what it says.
Q. And that was a pretty prestigious group, this Cochrane Collaboration Review Group; wasn't it?
A. Yes, it is.
The reason I hesitate is I was trying to remember if I've done a Cochrane review. I believe I have. I believe I've been a member of a Cochrane Collaboration on another topic.
MR. LEGER:

Please take that off.
EXAMINATION BY MR. LEGER:
Q. So, in fact, what they're saying is there's even evidence that mammography is not really a good thing to do? That there's no proof of mortality there; that's what they're saying? That that's one side of the argument; right?
A. Well, I would like to respond in a more -- in a slightly more complex fashion.
Q. I asked you to make me be precise. But if you could be brief.
A. I think what they did was introduce a new level of debate to the topic. And that they questioned something. But, at the same time, it

has -- I mean, the debate is ongoing. I think that's the main point.
Q. That's what I'm asking, Doctor.
Is it fair to say down here -- and you can read it, we're getting close, I'm not going to ask that that be displayed to the jury -- is it fair to say that right here, however, a bunch of other studies came back and other people said, well, we don't really agree and they picked apart the analysis and the scientific data and the evidence and said --
A. Right.
Yeah, I mean, that's exactly what they say. And they go on to say that the Cochrane report had not provided credible evidence to support their claim that there was no reliable scientific evidence that screening for bladder cancer reduced mortality.
Q. And, Doctor, my point is it's not usual, as

medical science advances, as, for example, mammography is being used or other screening devices are being used, for doctors to actually care for patients and have these tests performed on their patients and, at the same time, the scientific debate continues; right?
A. That is correct.
Q. Studies are done, there are changes in procedures, things you call algorithms can be changed as a result of studies? That doesn't mean you have to wait for randomized controlled trials that totally support the conclusion before you recommend on a good scientific basis, correct --
A. That is correct.
Q. -- that type of screening device?
A. That is correct.
Q. Doctor, with respect to --
You can remove that, please.
With respect to yesterday, I think, at length, there was discussion of the "However" language. Remember the recommendations of the American Cancer Society?
A. Yes, I remember that.
Q. It basically said the American Cancer Society does not recommend the use of lung cancer screening; is that correct?
A. "However."
Q. And then there was some "However" language; right?
A. Right. I noted that.
Q. Now, when they say they do not recommend, that doesn't mean they recommended against; did

they, Doctor?
A. That is correct.
Q. In fact, do you remember that those recommendations -- and I think your testimony was something to the effect of those recommendations basically said but we do, because of the level of scientific evidence with respect to early detection

of lung cancer, we do suggest it's a good idea for patients and doctors to talk about screening?
A. That is correct. In appropriate risk individuals.
Q. In appropriate risk individuals.
We're talking about people at high risk, cigarette smokers in the United States; right?
A. That is correct.
Q. In fact, we're talking about cigarette smokers and former smokers here in the State of Louisiana; right, Doctor?
A. That was my understanding.
Q. And they recommended further that, if you're going to do these things, that you do them in multidisciplinary institutions; right, Doctor?
A. Yes, they recommended that. I remember seeing the language.
Q. That's a specific recommendation of the American Cancer Society; right?
A. That was a recommendation.
Q. And, Doctor, in Louisiana, do we have multidisciplinary institutions?
A. Yes.
Q. I mean, we've got Tulane is one of those; isn't it?

A. Yes.
Q. Tulane Medical Center; right?
A. Yes.
Q. Dr. Brooks' Ochsner Medical Center is one of those multidisciplinary institutions?
A. That is correct.
Q. LSU-Shreveport is one of those multidisciplinary institutions; correct, Doctor?
A. Yes, that is correct.
Q. They've got one in Monroe?
A. Yes, that is correct.
Q. They've got one in Lafayette?
A. Yes.
Q. They've got one in Baton Rouge?
A. Yes.
Q. We've got others here in New Orleans?
A. Yes.
Q. Baptist Hospital, Memorial and --
A. There's a long list.
Q. Touro Infirmary?
A. Yes.
Q. LSU --
A. Yes, even LSU.
Q. -- is a multidisciplinary institution?
So we can do that in Louisiana; can't we, Doctor?
A. Yes.
Q. And, Doctor, I heard you and my friend, Willie Singleton, y'all come from small towns pretty close to each other outside of Shreveport?
A. That is correct.
Q. From Forbing?

A. That's where I'm from.
Q. Is that where you're from? And where did Willie say he's from? Frierson?
A. Frierson, yes.
I was shocked that anyone actually knew where Forbing was.
Q. So people in Coushatta, people in Edgard, people in Forbing and Frierson have access to multidisciplinary institutional centers here in the State of Louisiana; don't they?
A. Yes.
Q. People from Wilson have access to multidisciplinary institutions here in Louisiana for the early detection of lung cancer; right, Doctor?
A. I would assume if they can drive a little bit.
Q. And, Doctor, do we have an opportunity by the use here in Louisiana of low dose spiral CT for the early detection of lung cancer to affect the numbers that you showed yesterday as far as lung cancer deaths?
A. Yes, I believe that we do.
Q. Would you show us -- Never mind.
You said that there are projected to be 2,700 deaths --
A. Yes.
Q. -- in Louisiana?
A. I remember that. That's American Cancer Society data, 2,700 lung cancer deaths.
Q. Can that number be changed by the use of early detection procedures for lung cancer?
A. I believe that it could be.

Q. And what is your hope, Doctor?
A. My hope is that that would be very substantially reduced, and that the risk/benefit of doing so would be favorable.
MR. LEGER:
Your Honor, I have no more questions at this time.
THE COURT:
Step down, Doctor.
We will recess for today. 9:30 tomorrow morning. Be prompt. Thank you. Have a nice evening.
(Whereupon the jury is excused at this time.)
THE COURT:
Let the record reflect the jury has left the courtroom.
Anything for the record by plaintiff counsel?
MR. LEGER:
No, Your Honor.
THE COURT:
No? Defense counsel?
MR. WITTMANN:
No, Your Honor.
THE COURT:
Mr. Bruno?
MR. BRUNO:

Yes, Judge.
THE COURT:
I had Mr. Gianna suggest to you that we could do the testimony you wish to place

before me out of the jury's presence with regard to the video foundation.
Are you willing to do that at this point?
MR. BRUNO:
Yes, Judge, if you don't mind.
THE COURT:
Is Dr. Emory here?
MR. BRUNO:
Yes, Judge.
THE COURT:
Step up to the witness stand, please, Dr. Emory.
THE COURT:
Let's use this time to get these exhibits in order.

* * * * *

WILLIAM BROOKS EMORY, M.D., Ochsner Medical Institutions, Section of Pulmonary Diseases, 1514 Jefferson Highway, New Orleans, Louisiana 70121, after having been first duly sworn by the Law Clerk, testified on his oath as follows:

* * * * *

THE COURT:
And as I understand the agreed-to procedure, that Mr. Bruno will attempt to lay a foundation for the introduction of a video with Dr. Emory that Mr. Bruno will attempt to use in connection with Dr. Emory's testimony.
For the record, I viewed the video previously, so I've already seen it. And I

have read the comments that counsel made in the meeting with Mr. Gianna yesterday after the jury was discharged.
Mr. Bruno, are you ready to proceed?
MR. BRUNO:
Thank you, Judge.

VOIR DIRE EXAMINATION

BY MR. BRUNO:
Q. Dr. Emory, are you familiar -- And, Judge, for the record, we are referring to specifically W.E. Number 19, which is Scott Plaintiff Exhibit Number 312.01.
Dr. Emory, are you familiar with a videotape presentation which is entitled "Hugh McCabe: The Coach's Final Lesson"?
A. Yes, sir.
MR. BRUNO:
Mr. Herman reminds me, Judge, that I wonder if counsel would stipulate to the doctor's expertise as a pulmonologist for the purposes of offering for this testimony in

connection with this offer? Or should I make the tender now?

MR. LONG:

So stipulated.

EXAMINATION BY MR. BRUNO:

Q. All right. Doctor, are you familiar with the videotape presentation which is entitled "Hugh McCabe: The Coach's Final Lesson"?

A. Yes, sir.

Q. Where do you use it?

A. I use it in my presentation to adolescents

when I talk about the hazards of smoking.

Q. Where does it come from, Dr. Emory?

A. Well, actually, I saw this at an American Thoracic Society meeting. And it's published and I think it was sponsored by the American Thoracic Society.

Q. All right. Now, Doctor, would you please share with Judge Ganucheau approximately how many families that you've shepherded through the process of dying from the date of diagnosis of cigarette-related lung cancer to the date of the death?

A. Well, I've been practicing pulmonary medicine since 1974 at Ochsner Clinic, so we're in almost 30 years. We make diagnosis of lung cancer in our institution about 125 to 140 cases a year.

I probably have the largest proportion of people in my section in pulmonary medicine as far as the practice size. And I would say that, rounding numbers off, that I'm probably managing people in different facets of lung cancer probably at any one time, oh, 25 to 30 patients.

So over the period of time, unfortunately, I've probably been participating in the exodus of at least 500 to 600 people from lung cancer.

Q. Dr. Emory, in the process of shepherding families through this difficult time, have you had to associate yourself with the spouses of the person with the diagnosis of lung cancer?

A. Well, you take care of the patient and you take care of the family. The thing that is most distressing about this disease is that I've seen it wreck families. I mean, the emotional burden of

dealing with a patient dying really puts turmoil in through a structure of a family.

I mean, we deal with the children who have to deal with it, you deal with the spouse, you often have to deal -- sometimes make decisions relative to people in the workplace. You may have to make decisions that a patient is not able to work anymore, and that creates some conflict.

Q. Have you even had the occasion to deal with the friends of the person who has been diagnosed with lung disease?

A. Well, I've had to deal with, of course, the friends. And, unfortunately, I've had friends I've had to deal with who have had lung cancer.

Q. All right. Now, I'm asking you these questions, Doctor -- The Judge has already seen the tape, you've seen the tape. First of all, this tape is a documentary; is it not?
A. Yes.
Q. And it is, I believe -- Do you know whether or not the person who has been diagnosed and is dying on this tape from lung disease is a Louisiana resident?
A. No, he's from Maryland.
Q. Okay. Now, so this is the question, Doctor. Can you tell Judge Ganucheau whether or not, in your opinion, what is depicted on this documentary videotape is typical of the more than 500 cases, individuals that you've shepherded through the process of dying from lung cancer?
A. I think it has a very significant relationship to what we have to do. The gentleman

refers to his sons. I'm struck by the fact in the video that there's never any mention of his spouse, but I don't know what the details of that are. But he talks about his relationship.

And the theme which is also poignant to me is the relationship of his fellow teachers as they react to his illness. And then at the conclusion of the movie, they talk about -- they interviewed the children. And this is why I use this tape. I make this presentation at the different schools through the years.

And one of the things, as we all probably realize by now, by being an adult, that we don't have a great deal of credibility with 15- and 16-year-old kids. But they do identify with the story because the gentleman in the tape is 48 years of age, he's a teacher, and he's teaching in a middle school. So they can see someone they identify with.

So when the movie is over, for better or for worse, I have to say that the audience is very silent. And I think it has a very strong impact because it moves from the abstract of me walking around in an auditorium saying "Smoking is bad for you," and I show you a picture of a lung, and I show you a picture of a tongue partially cut out, and I show you the Dome stadium and I say, "Gee, if you think about it, if you filled that stadium twice with corpses, that's how many people will die from lung cancer this year," those are abstract terms.

But the movie makes them understand how devastating the illness is not only to the

individual who is dying from this unfortunate disease but the impact of all the people in his sphere of influence.
Q. Let's talk about that particular fact, Dr. Emory. You lecture children, you told the Judge; correct?
A. That's correct.

Q. And can you explain to Judge Ganucheau why, in your opinion, it is so important and it's so necessary to make individuals understand that the potential resultant from smoking cigarettes is death, and that has to be something that they can truly embrace and understand and feel?
A. Well, I mean, as I said earlier, my credibility with an 18-year-old or a 16-year-old is not too high. I have two in my house.

But the point is that we talk about an illness that will not affect them for 25, 30, 35 years. So it's very hard for them to understand that. This is the age group that drive cars fast and are willing to jump out of airplanes for your military. So mortality is really not high in their sphere of thought.

So my point is this movie brings home the reality of what goes on. And several years ago, unfortunately, I presented this movie to my group at St. Martin's. And one of the children's father had recently died from lung cancer, and it was tough on her and it was very tough on me.
Q. Doctor, you've been in this courtroom, you've watched the cross-examination of Dr. Sartor relative to the use of spiral CT as an early detection method

for lung cancer in order to improve outcomes with regard to lung cancer caused by smoking.

Now, this is the question, Doctor. This jury has heard about the numbers of people who die from lung cancer caused by cigarette smoking; this jury has already heard from Dr. Sartor a description, a verbal description, of dying with lung cancer.

What I'd like to know, Dr. Emory, is whether or not, in your opinion, this jury can truly understand the real impact of dying from lung cancer simply from listening to statistics and simply from hearing a general description of what it's like to die from lung cancer?
A. I don't think, unless you've been in the medical field or had a family member die of a chronic disease, that you have the emotional awareness of what it does to you.

And so, no, we are talking in abstracts, we're talking about stratification and things like that. And probably most of this is going over some people's heads.

But I think that, no, I don't think, unless they had a family member who died from an illness which -- And these are chronic illnesses. It's not like a heart attack where you die like that. And some of these people have seen or been affected by violent deaths or automobile accidents, et cetera.

But to live day in and day out and watch one of your loved ones waste away is very difficult. And it has to be personified.
Q. Doctor, I have to tell you, I don't remember specifically with regard to each of these 17 people

whether or not anybody died. But I want you to assume for the sake of this discussion that the defendants objected to jurors sitting on this jury, one, if they smoked any cigarettes; two, if their parents, brothers or sisters or children smoked any cigarettes; and, three, if they had any family members who died from smoking-related lung cancers.

If that's true, does that make what you just said more or less poignant with regard to using this evidence with this jury so that they will have the most complete and proper understanding of what it means to die from lung cancer caused by smoking?

MR. BELASIC:

Your Honor, I object to the question. The hypothetical is just wrong. I mean, alternate Juror 2 has an aunt that died from lung cancer. Two of our jurors smoked.

THE COURT:

Overruled.

MR. BELASIC:

He's suggesting they're not on the jury.

THE COURT:

Answer the question if you're able to.

A. The point I'd make is if the jury was selected in that fashion, they've been isolated from the realities of the harshness of this illness.

EXAMINATION BY MR. BRUNO:

Q. Now, I want to give you another hypothetical. Just assume that this is true. Let's assume that you were an observer in a courtroom. And you happened on a tobacco case. And you happened on the portion of the tobacco case where the Judge was

selecting jurors. And the Judge asked the jurors about their smoking history. And one of the jurors said that they were an experimental smoker.

And the Judge asked the experimental smoker, "When did you start smoking?" And the response was "When I was in high school." And the Judge asked, "When is the last time that you experimented with smoking?" And the response was "Last week." Whereupon everybody in the courtroom, the Judge, the other jurors, the lawyers, everybody started laughing.

Could you tell Judge Ganucheau, as an expert pulmonologist, whether or not this laughter has any relevance whatsoever to the business of demonstrating to this jury the seriousness of dying from lung cancer?

A. Well, I would think that if people were laughing relative to the fact that, quote, you're an experimental smoker, you're not taking a serious event seriously.

And if the analogy had been that the gentleman was doing experimental Russian roulette since he was 16, I don't think there would be a soul laughing. They'd be worried about him. And I'd be worried about this young man.

But I'm also worried, again, about relative awareness of the seriousness of this disease. A hundred and seventy-five thousand lung cancer deaths

alone and they're not clued in.
MR. BRUNO:
I'm sorry, Judge. A minute.
EXAMINATION BY MR. BRUNO:

Q. You were in the courtroom just a few moments ago when you heard the cross-examination and the suggestion was that there were only 27 cancers found, only 27.
Now, I don't know what was intended. But let's assume that the jury might have interpreted that to be a statement that 27 is a small number. Just assume that. Does that in any way affect your opinion as to whether or not this jury needs to see this videotape to understand the impact of death caused by lung cancer?
A. Well, if my understanding of the study, which I have read, 27 out of 28 nodules that were biopsied, Dr. Sartor made a very clear point, were found to be positive for lung cancer. And if you were able to save 27 lives out of that cohort, it's 2.8 percent of the group.
So if we went around this room and I could say I could save 3 percent of the people in this room's lives by taking an X-ray, I can guarantee you everybody would raise their hand.
MR. BRUNO:
I have no more questions on this point, Judge. Would you answer the questions --
THE COURT:
Any questions on the subject by defense counsel?
MR. LONG:
Yes. I've got a few, Your Honor.
VOIR DIRE EXAMINATION
BY MR. LONG:
Q. Hello, Dr. Emory. My name is Gary Long. We

met years ago at one of your depositions. But I'm sure you can't recall and I barely recall.
A. I remember. It was on the sixth floor of the 26-floor building across the street, yes, sir.
Q. Actually, I think it was in Phil Wittmann's office.
A. Okay. That was on the first floor.
Q. Yes. Okay.
A. Mr. Wittmann was nice enough to give me a coffee cup, I remember that.
Q. I remember he did that, too. I didn't get one.
A. You must not have said the right thing.
Q. Anyway, the film that you're talking about, what's the basis of your knowledge about the film? I mean, did somebody tell you about the film?
A. No, I was attending a American Thoracic Society meeting in -- don't ask me which city -- many years ago. And they were having things that we look at at society meetings, placards and posters. And one of the things was in the section under

"Antismoking."
And you walked up and there was a monitor and they were showing the movie. And I said -- And I sat there and I watched the movie. And I said, "Gee, this would be an ideal tool to couple with my vocal and slide presentation." I came back, called the American Thoracic Society, sent them a check for 32 dollars, and they sent me the tape.
Q. Okay. And, obviously, you've seen the tape many, many times?
A. Yes, sir.

Q. And the gentleman in there, Mr. McCabe, is that his name?
A. That's correct.
Q. You never met the gentleman?
A. No, he died. He died at the conclusion. He literally died in the movie.
Q. I've seen the clip.
But your knowledge that this is all a true story is based upon what somebody told you; correct?
A. It's based upon my view of the film. And my understanding that this is not an actor; this is a person's documentation as he passes away.
Q. I understand that.
A. That's my understanding.
Q. But your understanding that it's true is based upon looking at it rather than being there when it was made?
A. That is correct.
Q. Okay. Now, what's your understanding of what the plaintiffs are seeking to recover in this case?
A. Well, my understanding is that what we have been asked to look at is whether or not there is a modality known as medical monitoring that could be applied to a class of individuals who are at a higher risk for some diseases. And I think in the class there are four. And that the reason that they're at higher risk is from consumption of tobacco.
Q. So, basically, what the plaintiffs are seeking for the class is medical screening; would you agree with that?
A. I think the better word for me would be

medical monitoring.
Q. Okay. For you, medical monitoring.
And these are people who we don't know whether they have a disease or not; correct?
A. That is correct.
Q. And some may have a disease and some may not; correct?
A. That is correct.
Q. And do you understand that nobody is seeking damages for lung cancer in this case?
A. That is correct.
Q. And nobody is seeking damages for the pain and suffering of lung cancer in the case?
A. That is correct.

Q. And nobody is seeking damages on behalf of a spouse that's affected by somebody who has lung cancer; do you understand that?
A. That is my understanding.
Q. And nobody is seeking damages on behalf of the children of people who might have lung cancer; you understand that?
A. Yes, sir.
Q. And all of these areas are touched on in this clip, this video?
A. Correct.
Q. And you use the film because you think you need it to have credibility with youngsters that you're talking to?
A. What I'm trying to make the point is that I'm striving for prevention. I begin my opening remarks to whatever group I'm talking to is that I treat diseases which I have very little success in curing.

And my only thing is that I need to prevent you from being in my office 25 years from now from a disease that, if we get you never to smoke, you will never have to visit me.
Q. And it's a scary film; isn't it?
A. No, it's not a scary film. I think it's a very poignant film. "Scary" is not the right word. It's not a war movie; it's a human story.
Q. It has a big impact?
A. It has a good emotional impact, yes, sir.
Q. Well, you testified on direct that it had a big impact?
A. Yes, sir.
Q. And that's why you like to show the video?
A. Yes, sir.
Q. And do you think you can have credibility -- you saw the ladies and gentlemen of the jury -- do you think you can have credibility with these ladies and gentlemen?
A. I think so.

MR. LONG:
That's all I have. Thank you.
THE COURT:
Any other cross?
MR. WITTMANN:
No, Your Honor.
THE COURT:
Mr. Bruno?
MR. BRUNO:
Just very brief. Three questions, I think, I've gotten written down here.

RE-EXAMINATION BY MR. BRUNO:

Q. Doctor, isn't it true that the more you smoke, the higher the risk of lung cancer?
A. Yes, sir.
Q. All right. And one of the reasons that people continue to smoke, you've found in your practice, is because they believe it won't happen to them?

A. That's everyone's universal concept. It will be somebody else but me.
Q. All right. And, finally, true or not, that is, whether or not this fellow in this movie is truly dying, does it accurately depict dying from lung cancer?
A. Yes, sir.
MR. BRUNO:
That's it. Thank you, Judge.
Appreciate your time.
THE COURT:
I will take the issue under advisement.
And I will rule before --
MR. RUSS HERMAN:
Judge, --
THE COURT:
I'm not finished.
-- it is sought to be used tomorrow.
The question I want to ask is do you wish to attempt to authenticate the lungs tonight?
MR. LONG:
We don't need to.
THE COURT:
No problem with that?

MR. LONG:
They look like lungs to me.
MR. BRUNO:
Okay.
THE COURT:
Okay.
MR. BRUNO:
Judge, one other thing, though.
And, frankly, with Dr. Emory on the stand, if it's okay with you, you know and I know that Dr. Emory was asked to evaluate both Deania Jackson and Gloria Scott with regard to whether they had smoking-related pulmonary diseases. Now, you also know that he found lung cancer in Gloria Scott.
And I know this is a -- I'm asking you for a ruling in advance. But to be perfectly candid with you, Judge, we've all invested about ten years of our life in getting here and I don't want to make any mistakes in the direct of Dr. Emory. And I want to see if we can have a clear understanding of the rules.
My understanding of the rules is that I can ask him about the process of having Gloria Scott have a chest X-ray, about the process of having the spiral CT, about the process that the spiral CT revealed a nodule, about the process that the nodule was the subject of a lung biopsy which showed cancer, and that's exactly where I stop.
It is not my intention to suggest through Dr. Emory that this cancer is a

cigarette-related cancer; merely that the spiral CT, in fact, identified a nodule which, on biopsy, was found to be a cancer. And, no, I'm not getting into staging, absolutely not. That would be inappropriate.

MR. LONG:

I don't have a problem with that.

But, Your Honor, to let you know, it would be our intent, perhaps based upon the doctor's direct testimony, to go into stage of the disease when it was found. And we think that's relevant.

If for no other reason, and there are a lot of other reasons, in opening statements, plaintiffs' counsel, Mr. Carter, talked about "As this lawsuit began, Dr. Brooks Emory of Ochsner performed a safe and effective test that allowed him to diagnose Gloria's disease." Here's the important part. "Gloria is proof that early diagnosis is better."

They've opened the issue with the jury. And we may explore the stage of the lung cancer when it was found on the CT. That goes to the issue of whether early diagnosis is better.

MR. BRUNO:

Mr. Long is not telling you the whole story, unfortunately. Because in order for him to tell the jury why there's even an issue of staging, he has to talk about the fact that there was surgery and that there

was a pathological staging that was done after surgery.

So what he intends to do is talk about the pathological staging, and compare and contrast it to the clinical stage. Herein lies the rub. If he wants to cross that door, then we get into the whole surgery. We have to because there's no way to discuss pathological staging until you take out the chunk of the lung. And I see Dr. Emory nodding with me.

And so if we're going to not talk about treatment, then you can't talk about staging. And in my view, Judge, staging is wholly irrelevant to what this evidence is intended to demonstrate. It is merely intended to demonstrate that the CT found the nodule identified later to be a cancer through needle biopsy.

MR. RUSS HERMAN:

The Judge gave a special instruction after opening, Joe.

THE COURT:

All right. I just reviewed that instruction. I have it here.

MR. BRUNO:

Okay.

THE COURT:

We will recess until 9:30 tomorrow morning.
MR. BRUNO:
Judge, thank you.

MR. BELASIC:
Your Honor, --
THE COURT:
Just a moment. Do you have something to say?
THE WITNESS:
No, I just said "Thank you."
THE COURT:
You can step down.
THE WITNESS:
Okay. Thank you.
(Whereupon a discussion was held off the record.)
THE COURT:
Mr. Herman?
MR. RUSS HERMAN:
Yes, I know it's late. But we still haven't argued the special instruction and we still -- I know Your Honor has under advisement some other issues.
THE COURT:
Yes. I'm aware of all of them.
MR. RUSS HERMAN:
Yes, sir.
THE COURT:
Okay.
MR. RUSS HERMAN:
Thank you.
THE COURT:
We'll recess until tomorrow morning.
(Whereupon the proceedings were adjourned at 4:30 o'clock p.m.)

REPORTER'S CERTIFICATE

I, CHERYL FOURNET HUFFMAN, Registered Merit Reporter, in and for the State of Louisiana, as the officer before whom this testimony was taken, do hereby certify that this testimony was reported by me in the stenotype reporting method, was prepared and transcribed by me or under my personal direction and supervision, and is a true and correct transcript to the best of my ability and understanding; that I am not related to counsel or to the parties herein, nor am I otherwise interested in the outcome of this matter.

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